



Solicitation Information

17 March 10

Request for Proposals # 7323572

Title: Independent Audit Services - Disproportionate Share of Hospital Claims

Submission Deadline: 16 April 10 @ 11:00 AM (Eastern Time)

Questions concerning this solicitation must be received by the Division of Purchases at questions@purchasing.state.ri.us no later than **31 March 10 at 12:00 Noon (ET)**. Questions received, if any, will be posted on the Internet as an addendum to this solicitation. It is the responsibility of all interested parties to download this information.

SURETY REQUIRED: No

BOND REQUIRED: No

Jerome D. Moynihan, C.P.M., CPPO
Administrator of Purchasing Systems

Vendors must register on-line at the State Purchasing Website at www.purchasing.ri.gov

Note to Vendors:

Offers received without the entire completed three-page RIVP Generated Bidder Certification Form attached may result in disqualification.

THIS PAGE IS NOT A BIDDER CERTIFICATION FORM

SECTION 1 - INTRODUCTION

The Rhode Island Department of Administration/Office of Purchases is soliciting proposals from qualified firms to conduct independent certified audits of Disproportionate Share Hospital claims for the period SFY's 2005-2010, as described elsewhere herein, and in accordance with the terms of this Request and the State's General Conditions of Purchase (available at www.purchasing.ri.gov).

This is a Request for Proposals, not an Invitation for Bid: responses will be evaluated on the basis of the relative merits of the proposal, in addition to price; there will be no public opening and reading of responses received by the Office of Purchases pursuant to this Request, other than to name those offerors who have submitted proposals.

INSTRUCTIONS AND NOTIFICATIONS TO OFFERORS:

- Potential offerors are advised to review all sections of this Request carefully, and to follow instructions completely, as failure to make a complete submission as described elsewhere herein may result in rejection of the proposal.
- Alternative approaches and/or methodologies to accomplish the desired or intended results of this procurement are solicited. However, proposals which depart from or materially alter the terms, requirements, or scope of work defined by this Request will be rejected as being non-responsive.
- All costs associated with developing or submitting a proposal in response to this Request, or to provide oral or written clarification of its content, shall be borne by the offeror. The State assumes no responsibility for these costs.
- Proposals are considered to be irrevocable for a period of not less than sixty (60) days following the opening date, and may not be withdrawn, except with the express written permission of the State Purchasing Agent.
- All pricing submitted will be considered to be firm and fixed unless otherwise indicated herein.
- Proposals misdirected to other State locations or which are otherwise not present in the Division of Purchases at the time of opening for any cause will be determined to be late and may not be considered. The "Official" time clock is in the reception area of the Division of Purchases.
- In accordance with Title 7, Chapter 1.1 of the General Laws of Rhode Island, no foreign corporation shall have the right to transact business in the state until it shall have procured a Certificate of Authority to do so from the Rhode Island Secretary of State (401-222-3040). *This will be a requirement only of the successful bidder (s).*
- Offerors are advised that all materials submitted to the State of Rhode Island for consideration in response to this Request for Proposals will be considered to be public records, as defined in Title 38 Chapter 2 of the Rhode Island General Laws.
- Also, Submitters should be aware of the State's MBE requirements, which addresses the State's goal of ten per cent (10%) participation by MBE's in all State procurements. For further information, contact the State MBE Administrator at (401) 574-8253 or cnewton@gw.doa.state.ri.us Visit the website <http://www.mbe.ri.gov>

- Interested parties are instructed to peruse the Division of Purchases web site on a regular basis, as additional information relating to this solicitation may be released in the form of an addendum to this RFP / LOI
- Equal Employment Opportunity (RIGL 28-5.1)
 - § 28-5.1-1 Declaration of policy. - (a) Equal opportunity and affirmative action toward its achievement is the policy of all units of Rhode Island state government, including all public and quasi-public agencies, commissions, boards and authorities, and in the classified, unclassified, and non-classified services of state employment. This policy applies in all areas where the state dollar is spent, in employment, public service, grants and financial assistance, and in state licensing and regulation. For further information, contact the Rhode Island Equal Employment Opportunity Office, at 222-3090 or via email raymond1@gw.doa.state.ri.us
- *Subcontracts are permitted, provided that their use is clearly indicated in the offeror's proposal, and the subcontractor(s) proposed to be used are identified in the proposal.*
- If you wish to seek to do business with the State of Rhode Island, you must register and utilize the E-Verify Program. Please refer to www.dhs.gov/E-Verify or the Division of Purchases website at www.purchasing.ri.gov for more information.
- RIGL 37-13-3.1 State public works contract apprenticeship requirements. * (a) Notwithstanding any laws to the contrary, all general contractors and subcontractors who perform work on any public works contract awarded by the state after passage of this act and valued at one million dollars (\$1,000,000) or more shall employ apprentices required for the performance of the awarded contract. The number of apprentices shall comply with the apprentice to journeyman ratio for each trade approved by the apprenticeship council of the department of labor and training.
- **ARRA SUPPLEMENTAL TERMS AND CONDITIONS**
 For contracts and sub-awards funded in whole or in part by the American Recovery and Reinvestment Act of 2009. Pub.L.No. 111-5 and any amendments thereto, such contracts and sub-awards shall be subject to the Supplemental Terms and Conditions For Contracts and Sub-awards Funded in Whole or in Part by the American Recovery and Reinvestment Act of 2009. Pub.L.No. 111-5 and any amendments thereto located on the Division of Purchases website at www.purchasing.ri.gov."

SECTION 2 - BACKGROUND AND PURPOSE

BACKGROUND:

Title XIX of the Social Security Act (Act) authorizes Federal grants to States for Medicaid programs that provide medical assistance to low-income families, the elderly and persons with disabilities. Section 1902(1)(13)(A)(iv) of the Act requires that States make Medicaid payment adjustments for hospitals that serve a disproportionate share of low-income patients with special needs. Section 1923 of the Act contains more specific requirements related to such disproportionate share hospital (DSH) payments, including aggregate annual state-specific limits on Federal financial participation under Section 1923(f), and hospital-specific limits on DSH payments under Section 1923(g). Under those hospital specific limits, a hospital's DSH payments may not exceed the costs incurred by that hospital in furnishing services during the year to Medicaid patients and the uninsured, less other Medicaid payments made to the hospital, and payments made by the uninsured patients ("uncompensated care costs"). In addition, Section 1923(a)(2)(D) requires States to provide an annual report to the Secretary describing the payment adjustments made to each disproportionate share hospital. Section 1923(j)(1) of the Act requires States to submit an annual report, Section 1923(j)(2) of the Act requires States to have their DSH payment programs independently audited and to submit the independent certified audit annually to the Secretary and Section 1923(j) of the Act also makes Federal matching payments contingent upon a State's submission of the annual DSH report and independent certified audit.

PURPOSE:

The Department of Human Services (DHS), the State Medicaid Agency, is soliciting proposals to contract an independent CPA firm to perform Disproportionate Share Hospital (DSH) audits. The contract will be for a base term of one year with four (4) optional renewal years. Attachment A contains a list of the hospitals to be audited.

The first year of the contract resulting from this RFP will be an audit of the Medicaid State Plan (MSP) years 2005 and 2006, and 2007. Each subsequent year, beginning with MSP 2008, will be for one audit per year only. The contractor must review the criteria of the Federal audit regulation and complete the verification, calculations and report under the professional rules and generally accepted standards of audit practice. Certification of the audit would include a review of the State's audit protocol to ensure that the Federal regulation is satisfied, an opinion for each verification detailed in the regulation, and a determination of whether or not the State made DSH payments that exceeded a hospital's specific DSH limit in the Medicaid State plan year under audit. The certification should also identify any data issues or other caveats that the contractor identifies as impacting the results of the audit.

Section 1923(j)(2) of the Social Security Act requires States to have their DSH payment programs independently audited and to submit the independent certified audit annually to the Secretary. The certified independent audit must verify:

- The extent to which each hospital has reduced uncompensated care costs to reflect the total amount of claimed expenditures made under Section 1923 of the Act.
- DSH payments to hospitals comply with the applicable hospital-specific DSH payment limit.
- Only the uncompensated care costs of providing inpatient hospital care to Medicaid eligible individuals and uninsured individuals as described in Section 1923(g)(1)(A) of the Act are included in the calculation of the hospital-specific limits.
- The State included all Medicaid payments, including supplemental payments, in the calculation of such hospital specific limits.
- The audits conducted under the resulting contract must meet the requirements of 42 CFR parts 447 and 445, Final Rule, 73FR 77904, December 19, 2008. CMS has developed a General DSH Audit and Reporting Protocol (Attachment C) which the contractor will use in order to comply with this rule.

It will be the responsibility of all Rhode Island Hospitals, including Eleanor Slater Hospital, receiving DSH payments from the State of Rhode Island to make available to the auditors all audited and unaudited Medicare Care cost reports, including all work papers, for the DSH Plan year's covered by this Request for Proposal.

ATTACHMENTS:

- A. Hospitals
- B. Final Rule (Abridged)
- C. General DSH Audit and Reporting Protocol
- D. Additional Information on the DSH Reporting and Audit Requirements

SECTION 3 - SCOPE OF WORK

To be considered responsive to this RFP, offerors must possess and demonstrate within their proposal the following minimum requirements. An offeror's failure to meet these minimum prior experience requirements will cause their proposal to be considered non-responsive and their proposal will be rejected.

The contractor must retain persons with expertise and recent professional practice per the following minimum requirements:

1. The Audit Manager must be a CPA and have a minimum of five (5) years of experience with generally accepted accounting principles and financial auditing standards with specific expertise in the area of State and Federal Medicaid, Medicare and DSH policies, regulations and statutes. The experience requirements must be met through specific experience with United States principles and standards. The five years experience must have occurred within the last seven years.
2. All staff assigned to the project, including subcontractors, must have a minimum of one (1) year of experience with generally accepted accounting principles and financial statement auditing standards with specific expertise in the area of state and Federal Medicaid, Medicare and DSH policies, regulations and statutes. The experience requirements must be met through specific experience with United States principles and standards. The one year of experience must have occurred within the last five years.
3. If subcontractors are used, of the assigned staff, a minimum of 50%, including management positions employed by the contractor, must be direct employees of the prime contractor.

The Audit Report for Year 1 of the Contract (MSP years 2005, 2006, and 2007) must be complete by a date that allows the State to complete and submit its report to CMS not later than December 31, 2010 (assume not less than thirty days in advance). All other Audit Reports must be complete not later than September 30th of each year.

Introduction, Purpose and Goals

DHS is soliciting proposals to contract an independent CPA firm to perform Disproportionate Share Hospital (DSH) audits. The contractor will determine whether a desk and/or on-site audit is required. The first year of the contract resulting from this RFP will be an audit of the Medicaid State Plan (MSP) years 2005, 2006, and 2007. Each subsequent year, beginning with MSP 2008, will be for one audit per year only. The contractor must review the criteria of the Federal audit regulation and complete the verification, calculations and report under the professional rules and generally accepted standards of audit practice. Certification of the audit would include a review of the State's audit protocol to ensure that the Federal regulation is satisfied, an opinion for each verification detailed in the regulation, and a determination of whether or not the State made DSH payments that exceeded a hospital's specific DSH limit in the Medicaid State plan year under audit. The certification should also identify any data issues or other caveats that the contractor identifies as impacting the results of the audit.

Section 1923(j)(2) of the Social Security Act requires States to have their DSH payment programs independently audited and to submit the independent certified audit annually to the Secretary. The certified independent audit must verify:

- The extent to which a hospital has reduced uncompensated care costs to reflect the total amount of claimed expenditures made under Section 1923 of the Act.
- DSH payments to each hospital comply with its applicable DSH payment limit.
- Only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and uninsured individuals as described in Section 1923(g)(1)(A) of the Act are included in the calculation of the hospital-specific limits.
- The State included all Medicaid payments, including supplemental payments, in the calculation of such hospital specific limits.
- The audits conducted under the resulting contract must meet the requirements of 42 CFR parts 447 and 445, Final Rule, 73 FR 77904, December 19, 2008.

CMS has developed a General DSH Audit and Reporting Protocol which the contractor will use in order to comply with this rule. The DSH audit will rely on existing cost reporting tools and documents as primary sources for the data necessary to evaluate DSH payments against hospital specific DSH costs. Two of the primary source documents are the Medicare 2552-96 hospital cost report and audited hospital financial statements (and other auditable hospital accounting records).

General Audit Responsibility:

It is the contractor's responsibility to:

- Review State's methodology for estimating hospital's OBRA 1993 hospital-specific DSH limit and the State's DSH payment methodologies in the approved Medicaid State plan for the State plan rate year under audit.
- Review state's DSH audit protocol to ensure consistency with IP/OP Medicaid reimbursable services in the approved Medicaid State plan. Review DSH audit protocol to ensure that only costs eligible for DSH payments are included in the development of the hospital specific DSH limit.
- Compile hospital specific IP/OP cost report data and IP/OP revenue data to measure a hospital's DSH limit in auditable year. In determining this limit, the auditor must measure both components of the hospital specific DSH limit. To determine the existence of a Medicaid shortfall, Medicaid IP/OP hospital costs (including Medicaid managed care costs) must be measured against Medicaid IP/OP revenue received for such services in the audited State Plan rate year (including regular Medicaid rate payments, add-ons, supplemental and enhanced payments and Medicaid managed care revenues). Costs associated with patients with no source of third party coverage must be reduced by applicable revenues and added to any Medicaid shortfall to determine total eligible DSH costs.
- Compile total DSH payments made in auditable year to a hospital (including DSH payments received by the hospital from other States).
- Compare hospital specific DSH costs limits against hospital specific total DSH payments in the audited Medicaid State plan rate year. Summarize findings identifying any overpayments/underpayments to particular hospitals.

Independent Certified Audit:

The independent certified audit must verify the following:

- Verification 1: A hospital is allowed to retain that payment so that the payment is available to offset its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the Medicaid State plan year to Medicaid eligible individuals and individuals with no source of third party coverage for the services in order to reflect the total amount of claimed DSH expenditures.
- Verification 2: DSH payments made to a hospital comply with the hospital-specific DSH payment limit. For each audited Medicaid State plan rate year, the DSH payments made in that audited Medicaid State plan rate year must be measured against the actual uncompensated care cost in that same audited Medicaid State plan year.
- Verification 3: Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no third party coverage for the inpatient and outpatient hospital services they received as described in Section 1923(g)(1)(A) of the Act are eligible for inclusion in the calculation of the hospital-specific disproportionate share limit payment limit, as described in Section 1923(g)(1)(A) of the Act.
- Verification 4: For purposes of this hospital-specific limit calculation, any Medicaid payments (including regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments) made to a disproportionate share hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals, which are in excess of the Medicaid eligible individuals, which are in excess of the Medicaid incurred costs of such services, are applied against the uncompensated care costs of such services, are applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third party coverage for such services.
- Verification 5: Any information and records of all of its inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments; and any payments made on behalf of the uninsured from payment adjustments has been separately documented and retained by the State.

- Verification 6: The information specified in Verification 5 includes a description of the methodology for calculating a hospital's payment limit under Section 1923(g)(1) of the act. Included in the description of the methodology, the audit report must specify how the each hospital defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they received.

Specific Areas of Review:

1. MMIS Data

- State MMIS generated IP hospital payments, ancillary charges and routine days for the cost reporting period(s) covering the Medicaid State plan rate year under audit for each DSH hospital.
- State MMIS generated OP hospital payments and ancillary charges for the cost reporting period(s) covering the Medicaid State plan rate year under audit for each DSH hospital.

2. Approved Medicaid State Plan

- DSH hospital determination criteria and data used to determine eligibility for the Medicaid State plan rate year under audit.
- Medicaid State Plan DSH payment methodologies for the Medicaid State plan rate year under audit.
- State DSH payments to each hospital for the Medicaid State plan rate year under audit.
- State methodology for determining the hospital-specific DSH limit, the data used to determine such limit and the hospital-specific cost limit generated by methodology and data for the Medicaid State plan rate year under audit.

3. Medicare 2552-96 Hospital Cost Report

- Medicare 2552-96 hospital cost report(s) for the Medicaid State plan rate year under audit (finalized when available or as filed).

4. Audited Hospital Financial Statements and Other Auditable Hospital Accounting Records

- Hospital revenues from Medicaid managed care organizations, Medicaid payments from other States (regular payments including add-ons, supplemental and enhanced payments, DSH payments), and Medicaid IP/OP hospital payments from all sources other than the State from hospital financial reports and records for the cost reporting period(s) covering the Medicaid State plan rate year under audit.
- Hospital revenues from or on behalf of with no source of third party coverage for the hospital services provided.
- Days and charges for IP/OP Medicaid hospital services for services provided to out of state Medicaid patients.
- Days and charges for IP/OP hospital services provided to patients with no source of third party coverage for the hospital services provided.
- Days and charges for IP/OP hospital services provided to Medicaid managed care patients.

Additional requirements:

- Field work will be completed no later than June 30th of each contract year. The first year the field work will be completed no later than September 30, 2010. Audit Report
- The contractor will provide the Project Manager of the Office of Rate Review with an audit report no later than 45 days after completion of field work at each hospital. In addition, the contractor will provide the Project Manager with an electronic file of all supporting documentation and data supporting the contractor's audit process and findings. Upon issuance of audit report, the contractor will provide a bill for the remaining audit cost.
- The contractor will maintain all supporting documentation and data used in the contractor's audit process for a period of not less than 7 years following completion of an audit.

SECTION 4 - PROPOSAL SUBMISSION

Interested offerors may submit written questions for the purpose of clarifying the scope and intent of this requirement, as well as the evaluative criteria to be employed in the review of responses to this Request, on or before the date and time indicated on page one of this solicitation.

Interested offerors may submit proposals to provide the services covered by this Request on or before the date & time indicated on page one of this solicitation. Proposals received after this time and date will not be considered.

Proposals must include the following:

1. A completed and signed three-page RIVIP Bidder Certification Cover Form, available at www.purchasing.ri.gov
2. A Cost Proposal reflecting the hourly rate, or other fee structure, proposed for this scope of services, including completion of the Cost Proposal Summary form, enclosed, and
3. A *separate* Technical Proposal describing the qualifications and background of the applicant and experience with similar programs, as well as the work plan or approach proposed for this requirement.
4. A completed and signed W-9 (taxpayer identification number and certification). Form is downloadable at www.purchasing.ri.gov.
5. In addition to the multiple hard copies of proposals required, Respondents are requested to provide their proposal in electronic format (CDRom, Diskette, flash drive). Microsoft Word / Excel OR PDF format is preferable. Only 1 electronic copy is requested. This CD or diskette should be included in the proposal marked "original".

The Technical Proposal must contain the following sections:

- Executive Summary

The Executive Summary is intended to highlight the contents of the Technical Proposal and to provide State evaluators with a broad understanding of the offeror's technical approach and ability.

- Offeror's Organization and Staffing

This section shall include identification of all staff and/or subcontractors proposed as members of the project team, and the duties, responsibilities, and concentration of effort which apply to each (as well as resumes, curricula vitae, or statements of prior experience and qualification).

- Work Plan / Approach Proposed

This section shall describe the offeror's understanding of the State's requirement, including the result(s) intended and desired, the approach and/or methodology to be employed, and a work plan for accomplishing the results proposed. The description of approach shall discuss and justify the approach proposed to be taken for each task, and the technical issues that will or may be confronted at each stage on the project. The work plan description shall include a detailed proposed project schedule (by hospital, task and subtask), a list of tasks, activities, and/or milestones that will be employed to administer the project, the assignment of staff members and concentration of effort for each, and the attributable deliverables for each.

- Previous Experience and Background

This section shall include the following information:

- A comprehensive listing of similar projects undertaken and/or similar clients served, including a brief description of the projects,
- A description of the business background of the offeror (and all subcontractors proposed), including a description of their financial position, and
- The offeror's status as a Minority Business Enterprise (MBE) certified by the Rhode Island Department of Economic Development, and or a subcontracting plan which addresses the State's goal of ten per cent (10%) participation by MBE's in all State procurements.

Proposals (an original plus **five** copies) should be mailed or hand-delivered in a sealed envelope marked "RFP #7323572 , "Independent Audit Services: Disproportionate Share Hospital Claims" to:

DEPARTMENT OF ADMINISTRATION
OFFICE OF PURCHASES
ONE CAPITOL HILL
PROVIDENCE, RI 02908

NOTE: Proposals received after the due date and time listed on the cover sheet of this solicitation may not be considered. Proposals misdirected to other State locations or which are otherwise not present in the Division of Purchases by the scheduled due date and time will be determined to be late and may not be considered. Proposals faxed or e-mailed to the Division of Purchases will not be considered. The official time clock is located in the reception area of the Division of Purchases.

SECTION 5 - EVALUATION AND SELECTION

The State will commission a Technical Review Sub-Committee, which will evaluate and score all proposals, using the following criteria:

Staff Qualifications	15 points
Capability, Capacity, and Qualifications of the Offeror	15 points
Quality of the Work plan	15 points
Suitability of Approach/Methodology	15 points
Cost	40 points

[calculated as (lowest responsive cost proposal - this cost proposal) X 40 points]

Notwithstanding the foregoing, the State reserves the right to award on the basis of cost alone, to accept or reject any offers, bids, proposals, and to act in its best interest.

Proposals found to be technically or substantially non-responsive at any point in the evaluation process will be rejected and not considered further.

The State may, at its sole option, elect to require presentation(s) by offerors clearly in consideration for award.

The Technical Review Sub-Committee will present written findings, including the results of all evaluations, to the State Purchasing Agent, or his designee, who will make the final selection for this requirement.

COST PROPOSAL

Offeror: _____

Firm Fixed price for the completion of each Audit Report, by Medicaid State Plan year:

<u>MSP</u>	<u>Cost</u>
2005	\$ _____
2006	\$ _____
2007	\$ _____
2008	\$ _____
2009	\$ _____
2010	\$ _____
<u>Total</u>	\$ _____

Approved: _____

Title: _____

Date: _____

Attachment A
Disproportionate Share Hospitals

1. Eleanor Slater Hospital
2. Kent Hospital
3. Landmark Medical Center
4. Memorial Hospital
5. Miriam Hospital
6. Newport Hospital
7. Rhode Island Hospital
8. Roger Williams Hospital
9. South County Hospital
10. St. Joseph Health Services
11. Westerly Hospital
12. Butler Hospital
13. Bradley Hospital

Attachment B
Final Rule Abridged

[Federal Register: December 19, 2008 (Volume 73, Number 245)][Rules and Regulations

[Page 77903-77952]

From the Federal Register Online via GPO Access [wais.access.gpo.gov] [DOCID:fr19de08-17]

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Part III

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 447 and 455

Medicaid Program; Disproportionate Share Hospital Payments; Final Rule

[[Page 77904]]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 447 and 455

[CMS-2198-F]

RIN 0938-AN09

Medicaid Program; Disproportionate Share Hospital Payments

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule sets forth the data elements necessary to comply with the requirements of Section 1923(j) of the Social Security Act (Act) related to auditing and reporting of disproportionate share hospital payments under State Medicaid programs. These requirements were added by Section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

DATES: Effective Date: This rule is effective on January 19, 2009.

FOR FURTHER INFORMATION CONTACT: Venesa Day, (410) 786-8281; Rory Howe, (410) 786-4878; and Rob Weaver, (410) 786-5914.

SUPPLEMENTARY INFORMATION:

I. Background

Title XIX of the Social Security Act (Act) authorizes Federal grants to States for Medicaid programs that provide medical assistance to low-income families, the elderly and persons with disabilities. Section 1902(a)(13)(A)(iv) of the Act requires that States make Medicaid payment adjustments for hospitals that serve a disproportionate share of low-income patients with special needs. Section 1923 of the Act contains more specific requirements related to such disproportionate share hospital (DSH) payments, including aggregate annual state-specific limits on Federal financial participation under Section 1923(f), and hospital-specific limits on DSH payments under Section 1923(g). Under those hospital specific limits, a hospital's DSH payments may not exceed the costs incurred by that hospital in furnishing services during the year to Medicaid patients and the uninsured, less other Medicaid payments

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made to the hospital, and payments made by uninsured patients ("uncompensated care costs"). In addition, Section 1923(a)(2)(D) requires States to provide an annual report to the Secretary describing the payment adjustments made to each disproportionate share hospital.

Section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173, enacted on December 8, 2003) added Section 1923(j) to the Act to require States to report additional information about their DSH programs. Section 1923(j)(1) of the Act requires States to submit an annual report that includes the following:

Identification of each DSH facility that received a DSH payment under the State's Medicaid program in the preceding fiscal year and the amount of DSH payments paid to that hospital in the same year.

Such other information as the Secretary of Health and Human Services determines necessary to ensure the appropriateness of DSH payments.

Section 1923(j)(2) of the Act also requires States to have their DSH payment programs independently audited and to submit the independent certified audit annually to the Secretary. The certified independent audit must verify:

The extent to which hospitals in the State have reduced uncompensated care costs to reflect the total amount of claimed expenditures made under Section 1923 of the Act.

DSH payments to each hospital comply with the applicable hospital-specific DSH payment limit.

Only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and uninsured individuals as described in Section 1923(g)(1)(A) of the Act are included in the calculation of the hospital-specific limits.

The State included all Medicaid payments, including supplemental payments, in the calculation of such hospital-specific limits.

The State has separately documented and retained a record of all its costs under the Medicaid program, claimed expenditures under the Medicaid program, uninsured costs in determining payment adjustments under Section 1923 of the Act, and any payments made on behalf of the uninsured from payment adjustments under Section 1923 of the Act.

In addition to these reporting requirements, under Section 1923(j) of the Act, Federal matching payments are contingent upon a State's submission of the annual DSH report and independent certified audit.

II. Summary of the Proposed Regulations

On August 26, 2005, we published in the Federal Register (70 FR 50262-50268) a notice of proposed rulemaking implementing the reporting and auditing requirements for State Disproportionate Share Hospital payments. In this notice of proposed rulemaking, we proposed modifying the DSH reporting requirements in Federal regulations at 42 CFR 447 by providing the following changes to our regulations:

1. Reporting Requirements

To implement the reporting requirements in Section 1923(j)(1) of the Act, we proposed to modify the DSH reporting requirements in Federal regulations at 42 CFR 447.

We proposed to add a new paragraph (c) to the reporting requirements in Sec. 447.299.

We proposed to redesignate the documentation requirements in paragraph (c) as paragraph (d) and redesignate the deferrals and disallowances information in paragraph (d) as paragraph (e), respectively.

We proposed a list of information to reflect the data elements necessary to ensure that DSH payments are appropriate such that each qualifying hospital receives no more in DSH payments than the amount permitted under Section 1923(g) of the act.

We proposed that paragraph (c) would require each State receiving an allotment under Section 1923(f) of the Act, beginning with the first full State fiscal year (SFY) immediately after the enactment of Section 1001(d) of the Medicare Prescription Drug,

Improvement, and Modernization Act (MMA) and each year thereafter, to report to us the list of information detailed in an Reporting form, which was published in the September 23, 2005 correction notice entitled "Medicaid Programs; Disproportionate Share Hospital Payments".

We proposed that States will need to consider a Section 1011 payment when determining the hospital's DSH limit, because the total DSH payments should not exceed the total amount of uncompensated care at the hospital.

The information supplied on this spreadsheet would satisfy the requirements under Sections 1923(a)(2)(D) and 1923(j)(1) of the Act.

2. Audit Requirements

We explained the statute's requirement for States to verify their methodology for computing the hospital specific DSH limit and the DSH payments made to hospitals. As required by Section 1923(j)(2) of the Act, these five items identified in statute would provide independent verification that State Medicaid DSH payments comply with the hospital-specific DSH limit in Section 1923(g) of the Act, and that such limits are accurately computed.

In Sec. 455.201, we proposed that "SFY" stands for State fiscal year.

We proposed to define that an "independent audit" means an audit conducted according to the standards specified in the generally accepted government auditing standards issued by the Comptroller General of the United States.

We proposed adding a new Sec. 455.204(a) to reflect Section 1923(j) of the Act's requirement that each State must submit annually the independent certified audit of its DSH program as a condition for receiving Federal payments under Section 1903(a)(1) and 1923 of the Act.

We proposed to add a new Sec. 455.204(b) to reflect the requirement that States must obtain an independent certified audit, beginning with an audit of its State fiscal year 2005 DSH program.

We proposed a submission requirement within 1 year of the independent certified audit.

We proposed that in the audit report, the auditor must verify whether the State's method of computing the hospital-specific DSH limit and the DSH payments made to the hospital comply with the five items required by Section 1923(j)(2) of the Act.

III. Discussion of Public Comments

On August 26, 2005, we set forth a proposed rule implementing the reporting and auditing requirements for State disproportionate share hospital payments (DSH). In this notice of proposed rulemaking, we proposed several modifications to the DSH reporting requirements and detailed the statutory auditing requirements for States to verify their methodology for computing the hospital-specific DSH limit to ensure that DSH payments made to eligible hospitals do not exceed such limits.

We received 119 timely public comments, in response to the August 26, 2005, proposed rule. The comments came from a variety of correspondents, including professional associations, national and State organizations, physicians, hospitals, advocacy groups, State Medicaid programs, State Legislators, and members of the Congress. The following is a summary of the comments received and our response to those comments.

Comments and Responses, except those dealing with Auditing, have been omitted from this document in the interests of brevity and for the fact that they are not necessary for accomplishing the audit requirements of this RFP.

Comments and Responses re. Auditing:

C. Auditing

1. General

Comment: Many commenters questioned the ability of the States to actually collect this information and have an independent audit completed within one year after the end of SFY 2005. One commenter said that demanding 2005 cost report data for SFY 2005 also

means that most, if not all, of the cost report data forwarded to CMS will be as submitted by the hospitals because the States will not be able to review and audit the cost reports before the reporting deadline.

Response: The information required under the audit is readily available to hospitals and the State based on existing financial and cost reporting tools. As discussed above, we have revised the timing requirements to extend the length of time to submit required reports and audits to permit submission as late as the last day of the Federal fiscal year ending 3 years after the end of the Medicaid State plan rate year, with a special timing provision for the audits for 2005 and 2006, which will be due by December 31, 2009. We believe this accommodates most of these concerns. We also note that we expect that reports and audits will be based on the best available information. If audited Medicare cost reports are not available, the DSH report and audit may need to be based on Medicare cost reports as filed.

Comment: One commenter noted that most of the reporting requirements will require the hospital to report information directly to the State, and requested explanation of the State's due-diligence responsibility for confirmation/assurance of the completeness and accuracy of the data provided by the hospital?

Response: We expect that States will obtain needed information from the hospital's Medicare 2552-96 cost report, audited hospital financial statements, and other hospital accounting records, in combination with information provided by the States' Medicaid Management Information Systems.

Because these source documents are prepared for other purposes, no single document will contain the precise information needed for DSH reporting and auditing purposes. States will need to work with hospitals to develop a methodology that can be applied to these records to properly calculate uncompensated care costs incurred in furnishing hospital services for individuals without health insurance or other third party coverage. This methodology will need to exclude costs from the calculation costs for services furnished to individuals with third party coverage, prisoners, duplicate accounts, individuals included in calculating the Medicaid shortfall, charges associated with elective procedures, and any professional charges. The methodology must operate in such a way as to provide the State's independent auditor confidence that the data is an accurate representation of the hospital's eligible uncompensated care charge and revenue data.

Comment: A few commenters questioned access to hospital records and other jurisdictional issues. Such access would need to be discussed, decided and clarified for the States. State auditors may not have jurisdiction to audit private hospitals.

Response: States already have authority to obtain the primary data sources needed to complete the DSH audit and the accompanying report. Information can be obtained from existing cost reports and financial information. These documents would include the Medicare 2552-96 cost report, audited hospital financial statements, and hospital accounting records. States and auditors also have access to information from the States' Medicaid Management Information Systems. We expect that States and auditors will need to work with hospitals to develop a methodology that can be applied to these records to properly calculate uncompensated care costs incurred in furnishing hospital services for individuals without health insurance or other third party coverage.

Comment: A few commenters noted that although hospitals submit the newly required S-10 Worksheet (S-10) for their Medicare cost reports, the information required by that Worksheet does not directly parallel the data required in the new reporting requirements. In addition, although both seek determinations of hospitals' total uncompensated care costs, they apply different methodologies for calculating such costs. Thus, DSH recipients will be confronted with making one set of calculations for their annual reports and another for their State's annual DSH report. If States perform calculations with the requested data to determine DSH payments, why not discard (c)(6) through (c)(16), and instead request a copy of DSH payment calculations for all hospitals in a particular fiscal year? Each hospital's payment calculation could appear on separate pages or worksheets.

Response: Worksheet S-10 is not part of the Medicare 2552-96 step-down process used to allocate inpatient and outpatient hospital costs. The cost allocation process utilized in the 2552-96 cost report is considered a key component of determining Medicaid and uninsured hospital costs for purposes of calculating the hospital-specific DSH limit. The Medicare 2552-96 cost report, in conjunction with hospital financial information, including hospital accounting records and Medicaid Management Information Systems data, may be used to determine uncompensated care costs for the calculation of the hospital-specific DSH limits. We expect these calculations to rely primarily on existing information, as outlined in the General DSH Audit and Reporting Protocol that will be available on the CMS Web site. We recognize, however, there may be situations in which the hospital may have to work with the State to develop new data or methodologies to allocate or adjust existing data.

Comment: A few commenters said that currently, there is no one source of data to meet the increased reporting requirements. The sources of data are from various data warehouses and under various State and hospital management systems. The likelihood that data will not be from consistent data sets is possible.

Response: We expect these calculations to rely primarily on existing information, as outlined in the General DSH Audit and Reporting Protocol available on the CMS Web site. We recognize, however, there may be situations in which the hospital may have to work with the State to develop new data or methodologies to allocate or adjust existing data. And it may be necessary for auditors to develop methods to test, verify the accuracy of, and reconcile data from different sources. CMS has developed a General DSH Audit and Reporting Protocol available on the CMS Web site that may assist States and auditors to utilize information from each source identified above and develop the methods under which costs and revenues will be determined.

Comment: One commenter noted that one State Medicaid agency annually surveys all hospitals near the beginning of its fiscal year and hospitals report their data for a twelve month period, but this period does not match the State fiscal year. Further, the commenter noted difficulties in analyzing the data because Federal DSH payments are provided on a Federal fiscal year, and at changing match percentages. Another commenter indicated that another State's DSH payment program operates on a Federal fiscal year basis, which provides consistency with Medicare hospital payment systems, the timing of changes in their Federal financial participation rate and with the timing of their DSH allotment. These commenters noted that the requirement in the proposed regulation for States to report and audit their DSH and enhanced payment programs on a State fiscal year basis will cause significant administrative burden and will not accurately reflect the basis upon which the State is making payments.

Response: We have modified the regulation to indicate the Medicaid State plan rate year as the period subject to the annual audit. The basis for this modification is recognition of varying fiscal periods between hospitals and States. The Medicaid State plan rate year is the period which each State has elected to use for purposes of DSH payments and other payments made in reference to annual limits.

In instances where the hospital financial and cost reporting periods differ from the Medicaid State plan rate year, States and auditors may need to review multiple audited hospital financial reports and cost reports to fully cover the Medicaid State plan rate year under audit. At most, two financial and/or cost reports should provide the appropriate data. The data may need to be allocated based on the months covered by the financial or cost reporting period that are included in the Medicaid State plan period under audit.

CMS has developed a General DSH Audit and Reporting Protocol which will be available on the CMS Web site that may assist States in using the information from each source identified above and developing the methods under which costs and revenues will be determined.

Comment: Several commenters said this would be a reporting burden on Critical Access Hospitals and will distract from needed resources to provide services to the uninsured. One commenter noted that a reporting burden exists because hospitals may not keep self-pay collection logs.

Response: The DSH audit will primarily rely on existing financial and cost reporting tools currently used by all hospitals participating in the Medicare program and therefore, should not generally divert resources necessary to provide services to the uninsured. These documents would include the Medicare 2552-96 cost report, audited hospital financial information, and hospital accounting records in combination with information provided by the States' Medicaid Management Information Systems and the approved Medicaid State plan governing the Medicaid and DSH payments made during the audit period.

To the extent that hospitals do not separately identify uncompensated care related to services provided to individuals with no source of third party coverage from uncompensated care costs not eligible under the hospital-specific DSH limits, hospitals will need to modify their accounting systems to do so. Setting up an accounting category to aggregate charges and revenues associated with uninsured individuals receiving inpatient and/or outpatient services from a hospital should be an accounting system adjustment not far removed from the process of setting up an account for any other payer category.

For purposes of the initial audits, States and auditors may need to develop methodologies to analyze current audited financial information including hospital accounting records to properly segregate uncompensated costs.

Comment: A few commenters stated the regulation should provide more specificity about the level of precision expected in calculating the total cost of care. They noted that, due to the timing lag for reporting and auditing, some States use the hospital's latest available Medicare cost report to calculate that hospital's overall cost-to-charge ratio. In that instance, the commenters indicated that the State converts the Medicaid and uninsured charges to cost using the hospital's overall cost-to-charge ratio. The commenters also pointed out that relatively few hospitals have a cost reporting period that is the same as the State fiscal year and, therefore, there would be two cost reporting periods during a State fiscal year. The commenters asked if applying a hospital's latest available cost-to-charge ratio to that hospital's Federal fiscal year Medicaid and uninsured charges be an acceptable and reasonable method to calculate that total cost of care.

Response: We expect that State reports and audits will be based on the best available information. If audited Medicare cost reports are not available for each hospital, the DSH report and audit may need to be based on Medicare cost reports as filed. We note that hospitals must follow the cost reporting and apportionment process as prescribed by the Medicare 2552-96 cost report process. To the extent that these cost reports do not contain the precise information needed for the DSH calculation (for example, by not distinguishing the categories of uncompensated care costs that are needed), it may be necessary for hospitals to modify their accounting techniques. In those circumstances, for the initial audits, it will be necessary to review other source materials such as audited hospital financial records and other records, and to develop methodologies to determine the necessary information from such records. We expect States, independent auditors and hospitals to work cooperatively to develop such methodologies.

CMS has developed a General DSH Audit and Reporting Protocol which will be available on the CMS Web site that should assist States and auditors in utilizing information from each source identified above and developing methods to determine uncompensated costs of furnishing hospital services to the Medicaid and uninsured populations.

Comment: One commenter questioned how to identify, ``* * * costs incurred for furnishing those services provided to individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they receive."

Response: CMS has developed a General Audit and Reporting Protocol to provide guidance to States, DSH hospitals and auditors in the completion of the DSH audit. This Protocol includes general instructions regarding the types of information to be provided by hospitals to the State and its auditor as well as the calculations the auditor will make based on the data provided. Specifically, the protocol details the process of using the Medicare 2552-96 cost report, hospital cost to charge ratios and hospital charges for inpatient and outpatient hospital services for which the recipient had no source of third party coverage. The protocol also details the process for determining eligible Medicaid uncompensated care for the Medicaid State plan rate year under audit. The protocol will be available on the CMS Web site.

Comment: One commenter noted that identifying uninsured patients is complicated by the restrictions on which uninsured patient accounts qualify (for example, if one cannot claim accounts denied due to medical necessity issues). This requires a painstaking and time-intensive process of reviewing each account history to identify the reason that an insurance company did not pay.

Response: To the extent that hospitals do not separately identify uncompensated care related to services provided to individuals with no source of third party coverage from uncompensated care costs not eligible under the hospital-specific DSH limits, hospitals will need to modify their accounting systems to do so. Setting up an accounting category to aggregate charges and revenues associated with uninsured individuals receiving inpatient and/or outpatient services from a hospital should be an accounting system adjustment not far removed from the process of setting up an account for any other payer category.

For purposes of the initial audits, States and auditors may need to develop methodologies to analyze current audited financial information, and hospital accounting records to properly segregate and identify DSH eligible uncompensated care costs.

Comment: One commenter noted that a State's Department of Social Services signed a Partnership Plan for the purpose of ``establishing a stable funding mechanism for the State's Medicaid program that embodies accountability while assuring the availability of financial resources to provide needed health care to the program's beneficiaries." The commenter noted that additional auditing and reporting requirements, as addressed in the proposed regulation, seem to be unduly burdensome and potentially costly to the State and the hospitals.

Response: Section 1923(j) of the Act contains audit and reporting requirements applicable to all States that make DSH payments. As part of this process, CMS must determine if all hospitals receiving DSH payments under the Medicaid State plan actually qualify to receive such payments and that actual DSH payments do not exceed the hospital-specific DSH limit for the same period.

To the extent that a State makes DSH payments within a Section 1115 waiver demonstration and/or a Partnership Plan, the State is not exempted from the rules surrounding DSH payments, particularly those at 1923(g) of the Act, and the audit and reporting requirements would still apply to that State.

It should be noted that the Partnership Plan primarily addresses funding of the Medicaid program, and is not relevant to the issue of whether particular payments are authorized under the approved Medicaid State plan and may be the basis for FFP under the Federal statute. Funding issues are not the subject of this regulation.

Comment: A few commenters suggested the creation of a \$500,000 threshold of DSH payments before an in-depth audit pursuant to 42 CFR 455, new Subpart C is triggered. Many small hospitals have historically low DSH allotments, and the administrative costs

of the proposed DSH reporting and auditing requirements are disproportionately onerous. If this exemption is not possible, the commenters request that any State with a DSH allotment under \$500,000 be allowed to use a hospital's independent auditor attestation to meet the audit requirements for hospital data used in DSH calculations. A few commenters suggested that CMS consider evaluating whether the cost associated with detailed audits are justified and whether an audit that reviews a sample of hospitals annually might be just as effective and considerably less costly. One commenter recommended that the requirement be to verify that the State's calculation formula provides for inclusion of only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage.

Response: There is no statutory authorization for an exception to audit and reporting requirements with respect to hospitals that receive low DSH payments. The audit and reporting requirements under Section 1923(j) of the Act apply to all States that make DSH payments, with respect to each hospital receiving a DSH payment. The statute further requires that CMS obtain information sufficient to verify that such payments are appropriate.

Relying on a sample of cost reports and financial information will not ensure that each DSH payment is appropriate and does not exceed the hospital-specific DSH limit.

The data elements necessary for the State to complete the DSH audit and report should, in part, be information the State already gathers to administer the DSH program. The responsibility of the auditor is to measure DSH payments received by a hospital in a particular year against the eligible uncompensated care costs of that hospital in that same year as determined using the data provided in the cost, utilization and financial reporting documents described above.

Finally, auditing a State's overall DSH payment methodology will not ensure that DSH payments to each hospital do not exceed the statutorily required hospital-specific DSH limit.

Comment: Commenting State Medicaid offices stated that the Medicaid program already represents a huge audit task for their offices, and that adding the additional responsibility of auditing hospital data for each hospital receiving a DSH payment would be an extremely large amount of additional work that would be nearly impossible to fit within required time frames. One commenter said that unless this requirement can be met through the acceptance of evidentiary documentation from the qualifying hospitals, further verification can only be made by the auditors' actual observation of the hospitals' records. The commenter complained that sending auditors to physically visit every qualifying hospital is onerous and expensive and the commenter questioned whether it is CMS' intent to require this extensive a drill-down.

Response: Section 1923(j) of the Act instructs States to audit and report specific payments and specific costs. The responsibility of the auditor is to measure DSH payments received by a hospital in a particular year against the uncompensated care costs for the Medicaid and uninsured populations incurred by that hospital in that same year. The auditor must follow accepted audit standards and develop sufficient confidence in the data to certify the results.

CMS has developed a General DSH Audit and Reporting Protocol to provide guidance to States, DSH hospitals and auditors in the completion of the DSH audit. This protocol provides general instructions regarding the types of information to be provided to the State and its auditor as well as the calculations the auditor will make based on the data provided. The Protocol will be available on the CMS Web site.

Comment: Several commenters noted that a reconciliation that must be completed no later than one year after the completion of each State's fiscal year will place a substantial burden on hospitals. They asserted that this would mean that hospitals will have to provide the State with uncompensated care data for FY 2005 before it is required for the FY 2007 DSH computation. They further indicated that this is not practical, because uninsured patients are difficult to identify until all collection efforts with other payers have been pursued, which can take several years.

Response: As discussed above, we have revised the timing requirements to extend the length of time to submit required reports and audits to permit submission as late as the last day of the Federal fiscal year ending 3 years after the end of the Medicaid State plan rate year, with a special timing provision for the audits for 2005 and 2006, which will be due by December 31, 2009. We believe this accommodates most of these concerns. We also note that we expect that reports and audits will be based on the best available information. If audited Medicare cost reports are not available, the DSH report and audit may need to be based on Medicare cost reports as filed.

Comment: A few commenters said that CMS should not impose unnecessary administrative burdens that will raise costs for * * * hospitals and States (that ultimately will be shared by the Federal Government) that result neither in improved quality or access nor in any measurable gain in accuracy or efficiency, particularly at this time when Congress and the Administration are intently focused

on reining in Medicaid expenditures. They argued that diversion of scarce hospital resources from other productive activities to achieve, at best, only marginal gains in accuracy of the uncompensated care cost calculation should be reconsidered. The increased costs outweighing the benefit of the reconciliation mandate.

Response: Section 1923(g)(1)(A) of the Act specifies that DSH payments cannot exceed a hospital-specific limit. Section 1923(j) of the Act, as added by the MMA, instructed States to audit and report DSH payments made by States and compare those payments to the uncompensated care costs as set forth in that hospital-specific DSH limit. This regulation implements those statutory audit and report requirements and is not a discretionary agency action.

We expect that States and auditors will rely on existing financial and cost reporting processes currently used by all hospitals participating in the Medicare program and therefore should not create an undue burden on states and hospitals in reporting compliance with Federal Medicaid law.

CMS has developed a General Audit and Reporting Protocol to provide guidance to States, DSH hospitals and auditors in the completion of the DSH audit. This protocol provides general instructions regarding the types of information to be provided to the State and its auditor as well as the calculations the auditor will make based on the data provided. The Protocol will be available on the CMS Web site.

Comment: One commenter noted that neither the MMA nor the proposed rule clearly state if the independent auditor is providing an opinion on whether the State's calculation formula includes "Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage * * *", or whether the intent is for the independent auditor to perform an in-depth annual audit of the hospitals records and cost reports in order to verify the hospital reporting processes as well as audit the State's methodology.

One commenter questions whether the requirement is that each State hire an auditor to look at each hospital's uninsured calculations.

Response: Section 1923(j) of the Act, as added by the MMA requires States to audit and report on hospital-specific DSH payments and this rule makes clear that this obligation includes specific cost data. The responsibility of the auditor is to measure DSH payments received by a hospital in a particular year against the eligible uncompensated care costs of that hospital in that same year.

States and auditors will need to obtain data from hospitals and may need to work with hospitals to develop new data or methodologies to allocate or adjust existing data. And it may be necessary for auditors to develop methods to test, verify the accuracy of, and reconcile data from different sources. This audit function is not the same as the function of the hospital's own auditors, however, and would not involve a review of the hospital's financial controls and internal reporting procedures. But the auditors must review the overall methodology for accumulating data to ensure that the resulting data reflects the required elements. In other words, the independent auditors must review the methodology for arriving at hospital-specific data, and must have confidence that the data accurately represents the hospital's eligible uncompensated care costs consistent with the statutory criteria.

Comment: One commenter said that in their State hospital representatives are required to sign a survey of data for DSH purposes, in order to certify that the data is accurate and in accordance with hospital records. There is a requirement that hospitals maintain the supporting documentation for potential audits. The commenter asked if this process was sufficient or whether all the supporting documentation needed to be housed at the Medicaid agency.

Response: Section 1923(j) of the Act requires audit and report of hospital-specific DSH payments and hospital-specific uncompensated care costs. While survey data submitted by the hospital may be an important source of information, the auditors may need to examine the methodology followed to arrive at that survey data, and may need to develop methods to test, verify the accuracy of, and reconcile data from different sources. One ultimate responsibility of the auditor is to compare DSH payments received by a hospital in a particular year with the actual eligible uncompensated care costs incurred by the hospital in that same year. Unreviewed survey data is not sufficient to satisfy the statutory instruction of the MMA.

CMS has developed a General DSH Audit and Reporting Protocol to provide guidance to States, DSH hospitals and auditors in the completion of the DSH audit. This protocol provides general instructions regarding the types of information to be provided to the State and its auditor as well as the calculations the auditor will make based on the data provided. The Protocol will be available on the CMS Web site.

Comment: Many commenters stated that the auditing requirements are costly and burdensome to both the hospitals and the State, creating another source of disincentive to hospital participation. The commenters request CMS be mindful of the additional financial costs that hospitals would incur and compensate hospitals accordingly.

Response: CMS believes that audits will rely primarily on documents already available to hospitals, and thus the audit data burden will neither be significant nor costly. CMS also believes that it is unlikely that a hospital will decline to receive Medicaid DSH payments merely because they must provide information to the State to verify that DSH payments do not exceed the hospital's DSH eligible uncompensated care costs.

Comment: One commenter asked whether the "independent audit" is a financial audit, or an audit of agreed-upon procedures. The commenter indicated that, if it is an audit of agreed-upon procedures, it would be helpful if audit program and procedures clarification were provided by CMS.

Response: The purpose of the audit is to ensure that States make DSH payments under their Medicaid program that are in compliance with Section 1923 of the Act. The nature of the audit encompasses both program and financial elements making it impossible to label as a traditional financial or programmatic/governmental audit.

The audit review of the State's Medicaid program is limited to ensuring that DSH payments are consistent with the approved Medicaid State plan and Federal statutory limits. The DSH audit will rely in part on financial, accounting and cost report data provided by hospitals. This data should be subject to generally accepted accounting principles, and auditors may need to verify the methodology used for calculating such data. These financial elements will demonstrate that Federal payments were claimed in compliance with Federal statutes.

Comment: One commenter's opinion about the most practical manner in which the State could meet this regulation is to require hospitals to expand their current financial audits to include the appropriate hospital-related compliance issues and have their uncompensated care data audited as part of their annual financial statement audit. Auditors of the Medicaid program (as part of the State's Single Audit) could then rely on these audited certifications and evaluate each State's DSH payment calculations and other information being reported by the State to the Secretary.

Response: The statute places audit and reporting requirements upon States, and these regulations reflect those requirements. These regulations do not impede States from developing procedures to meet these requirements that place particular burdens on hospitals receiving DSH payments. For example, States may establish procedures for hospitals to provide detailed audited data that can be relied on by the independent certified DSH auditors. We do not agree that these procedures can completely substitute for an independent certified audit obtained by the State itself. Nor do we agree that the State's single audit can substitute for the DSH audit responsibility under Section 1923(j) of the Act. The purpose of the State's single audit is different from the DSH audit responsibility, and we read the statute to require a distinct, focused review of DSH payments.

Comment: Several commenters recommend that CMS accept the current audit processes of their State. One commenter said that hospitals in the State that are currently required to complete annual certified independent audits of their uncompensated care data are only required to perform audits using generally accepted accounting principles and strongly recommended that the definition be changed so that audits may be performed under those principles already in place for a hospital's audited financial data. The hospitals of some States already independently certify uncompensated care data submitted to the State and submit these audited financial statements along with their annual cost reports. The information in the cost reports comes from the hospitals' accounting systems that have been independently audited. Another commenter recommended that CMS exempt States with satisfactory independent certification programs already in place from this provision.

Response: The statute places audit and reporting requirements upon States, and these regulations reflect those requirements. These regulations do not impede States from developing procedures to meet these requirements that place particular burdens on hospitals receiving DSH payments. For example, States may establish procedures for hospitals to provide detailed audited data that can be relied on by the independent certified DSH auditors. We do not agree that these procedures can completely substitute for an independent certified audit obtained by the State itself. Nor do we agree that the State's single audit can substitute for the DSH audit responsibility under Section 1923(j) of the Act. The purpose of the State's single audit is different from the DSH audit responsibility, and we read the statute to require a distinct, focused review of DSH payments.

Comment: Numerous commenters noted that the proposed requirement that the audit must be conducted pursuant to the government auditing standards is unduly burdensome. Most auditors in the private sector use generally accepted accounting principles ("GAAP") to audit hospitals' financial data. Thus, the independent auditors involved in performing hospital audits and who

use the GAAP standards to do these audits may not even be familiar with the generally accepted government auditing standards. In any case, it is inefficient to require these auditors to perform another audit of the same data using different auditing standards. At a minimum, States or hospitals should be allowed to use either the GAAP standards or the government auditing standards in meeting the audit requirements.

Response: Generally Accepted Government Auditing Standards (GAGAS) are the principles governing audits conducted of government organizations, programs activities, functions or funds. In general, government audits are either performance audits or financial audits. In either type, the focus is on the government entity, its management of a program and/or the financial management and reporting systems associated with that program.

The fact that there are some differences between GAGAS and GAAP, however, is a further reason why hospital audit efforts and the DSH audit have separate focuses and require separate analyses.

The DSH audit and report is a statutorily required component in the administration of the Medicaid program. The purpose of the audit is to ensure that States make DSH payments under their Medicaid program that are in compliance with Section 1923 of the Social Security Act. The audit does not encompass the review of the State's Medicaid program, it simply ensures that one portion of the program is conducted in line with Federal statutory limits. In addition, the DSH audit will rely on financial and cost report data provided by hospitals that are subject to generally accepted accounting principles as part of their primary reporting function.

Comment: One commenter said some auditors may find that base year figures cannot be verified to the extent necessary to provide a valid base because data or audit trails not previously necessary, are now required.

Response: States and auditors will need to obtain data from hospitals and may need to work with hospitals to develop new data or methodologies to allocate or adjust existing data. And it may be necessary for auditors to develop methods to test, verify the accuracy of, and reconcile data from different sources.

Comment: One commenter noted that the proposed rule appears to have greatly expanded the required scope (of Section 1923(j)(2)(E)) by making the State responsible for retaining documentation of patient-specific data. Assuming that CMS does not intend to place such a reporting burden on the States, the commenter requested that CMS clarify that the documentation requirement for hospital-reported data is limited to collecting, documenting and retaining State data and does not include documentation for data that a hospital might otherwise have available.

Response: States and auditors will need to work with hospitals to determine the extent to which original patient-specific source data is required and needs to be retained by the State.

2. Timing of Payments Under Review

Comment: A few commenters questioned whether DSH payments made by a State after SFY 2005 for dates of services prior to SFY 2005 are subject to the new auditing and reporting requirements. They noted that, currently, a few States make DSH payments after receipt of settled cost report from the Medicare fiscal intermediary and applies the DSH allotment based on dates of service. For example, one State made its DSH payment in SFY 2003 for dates of service in 2000 (using the 2000 Federal DSH allotment and settled Medicare cost reports).

Response: Unless otherwise specified in a State plan, the year in which payment is contemplated and accrues (even when subject to adjustment) is the DSH rate year to which it applies. Many States have provisions that provide for DSH payments based on prior year data, but that does not mean that those payments are prior year payments. (In the cited example, if that was the case, then the effect of any change in the DSH payment methodology would take three years to result in payment changes.) Each State should be aware of the Medicaid State plan rate year for which a DSH payment is made.

Comment: A few commenters said while Medicaid related data is readily available directly to the State, data regarding Medicare payments and discharges and non-Medicaid/non-Medicare data is not readily available to the State in efficient formats and timeframes required by the proposed rule.

Response: The commenter specifically questions the availability of non-Medicaid hospital data necessary to complete the audit. The only non-Medicaid related data relevant for the DSH audit would be the inpatient and outpatient hospital charges to individuals with no source of third party coverage. This information is available in hospital accounting records. Since the deadline for reporting

the audit findings has been extended to at least three full years after the close of the Medicaid State plan rate year subject to audit, hospitals would have necessarily included this charge data in their as-filed Medicare cost reports.

Comment: One commenter noted it would avoid misunderstanding if CMS clarified whether the required data element refers to gross revenue (full charges for services) or net revenue (expected collections after revenue adjustments.)

Response: Uncompensated care costs under the hospital-specific DSH limit are calculated by reducing costs incurred in furnishing hospital services to the Medicaid and uninsured populations, reduced by revenues received under Medicaid (not including DSH payments) and further reduced by payments received from or on behalf of the uninsured population (not including payments made by a State or local government for services to indigent patients).

Comment: Many commenters recognized that the proposed regulations are effective for SFY 2005 and stated it is inappropriate to require an audit for SFY 2005, when the rule outlining the required data to be audited had only been proposed two months after the close of SFY 2005 (August 26, 2005). The commenters urged a prospective application of these requirements effective for the first State fiscal year that begins after the date the final rule is issued, to allow sufficient time for respondents to identify data being required and processes to accumulate such data. A few commenters said the proposed regulation is impossible for both States and hospitals from an operational standpoint because this methodology uses actual costs and payments, and because of the deadlines for the audits and reports, neither Medicaid payments nor audited cost information are available. Numerous commenters stated that should CMS require an independent audit, it would be virtually impossible for States to meet the one-year filing deadline.

Response: The statutory provision at Section 1923(j) of the Act requires audits and reports for fiscal year 2004, but we are implementing this provision prospectively with Medicaid State plan rate year 2005, because that is the first Medicaid State plan rate year that necessarily begins in or after Federal fiscal year 2004. With that clarification, and because audits are prospective activities, we do not believe this rule has any retroactive effect. Moreover, as discussed above, CMS has modified the regulation to address the timing concerns expressed by these commenters. The regulation has been modified to:

1. Identify the Medicaid State plan rate year 2005 as the first time period subject to the audit requirement.
2. Extend the time period for submission of completed audit reports to the last day of the Federal fiscal year (FFY) ending three years from the Medicaid State plan rate year under audit. This means that the 2007 Medicaid State plan rate year must be audited by the last day of FFY 2010.
3. Provide for a special transition time period for concurrent completion of Medicaid State plan rate year 2005 and 2006 audits by September 30, 2009.
4. Provide for submission of each audit report within 90 days of the completion of the audit.
5. Provide for a transition period for reliance on audit findings, so that audit findings will not be given weight until Medicaid State plan rate year 2011 and thereafter in calculating uncompensated care cost estimates and associated DSH payments.

Comment: Many commenters said that this requirement could not be met if the regulations required a retrospective audit, because final settlement of hospitals' cost reports is typically contingent upon completion by a Medicare intermediary of audits that can take several years. One commenter noted that the requirement that the certified audit be completed one year after the close of the fiscal year is unattainable because the majority of the data required can only be derived from the Medicaid cost report, which is submitted no sooner than five months after the end of the fiscal year. Given the detail involved in the audit, the commenters indicated that there will not be enough time to receive cost reports, review and settle the reports, and provide data to the auditor, who would need to certify this tentatively settled cost report data for each of the States' DSH providers. One commenter stated that the regulation should be clarified to permit the required report to be based on a hospital's as-filed cost report, and time should be allowed for States to collect the additional data needed to meet the reporting requirements. One commenter said the hospitals in the State accumulate and report costs based on the hospital's fiscal year utilizing the audited Medicare cost report (HCFA-2552-96) which is generally not available before 21 months after the hospital's year end. Moreover, the commenter indicated that such reports do not use the same fiscal year as the SFY, and thus the cost information is not available on a SFY basis. The commenters also indicated that timing issues are also complicated by the fact that Medicaid claims may be submitted by hospitals to the State up to one year after the date of service.

Response: We discussed above the revisions made to address comments on timing issues and extend the time frames for reporting and auditing requirements. We expect that reports and audits will be based on the best available information. If audited Medicare cost reports are not available, the DSH report and audit may need to be based on Medicare cost reports as filed. We

recognize that, in many instances, hospital financial and cost report periods will differ from the Medicaid State plan rate year. In these instances, States and auditors may need to use multiple audited financial reports and hospital cost reports (CMS 2552-96, finalized when available or as-filed) to fully document the appropriateness of DSH payments for the Medicaid State plan rate year under audit. The data would then be allocated based on the months covered by the financial or cost reporting period that are within the Medicaid State plan period under audit. For instance, if a Medicaid State plan rate year runs from July 1, 2004 through June 30, 2005, but a DSH hospital receiving payments under the Medicaid State plan operates its financial and cost reporting based on a calendar year, the State and auditors may need to use information from financial and cost reports for calendar years 2004 and 2005. Costs and revenues of serving the Medicaid and uninsured populations would be allocated from each financial and cost reporting period, in this case half from each report, to determine the data for Medicaid State plan rate year 2005.

Comment: One commenter said that due to delays in receiving settled cost reports from Medicare Intermediaries, a State may distribute more than one year of DSH payments to hospitals in a given State Fiscal Year. The commenter asks for confirmation that the State should submit a separate Annual DSH Report for each year of DSH payments, regardless of the date of DSH payment.

Response: The DSH Audit must be performed and reported to CMS on an annual basis, which should reflect the basis for all DSH payments made for the Medicaid State plan rate year, even if the DSH payment for that period is made in a subsequent year.

Comment: A few commenters questioned whether a detailed audit manual should be prepared by CMS in order to assure compliance with the rule when promulgated and to avoid disputes after payments have been made.

Response: CMS has developed a General DSH Audit and Reporting Protocol to provide guidance to States, DSH hospitals and auditors in the completion of the DSH audit. This Protocol includes general instructions regarding the types of information to be provided by hospitals to the State and its auditor as well as the calculations the auditor will make based on the data provided. The Protocol will be available on the CMS Web site.

3. Audit Objective and Data Sources

Comment: Several commenters expressed their opposition to the audit aspect of the proposed regulation. While recognizing the need for audits, the commenters believe that the audits should fulfill only the following three objectives: determine whether individual States are following their own formulas for the calculation of DSH payments and hospital-specific DSH payment limits; verify the accuracy of States' calculations; and determine whether individual States are making good-faith efforts to make those calculations in compliance with Federal guidelines. The commenters believe the proposed regulation exceeds these three objectives. The commenters hope that CMS will instruct auditors that there are, in fact, various ways for States to make these calculations while remaining in compliance with Federal guidelines.

Response: Section 1923(j) of the Act requires that States audit actual DSH payments made under the approved Medicaid State plan against actual eligible uncompensated hospital costs in the same time period. Hence, the audit requirement necessarily will measure whether DSH payments made under the formulas in the approved Medicaid State plan are within the hospital-specific DSH payment limits as calculated by the State. The Medicaid State plan includes the reimbursement methodologies States utilize to make Medicaid DSH payments. While States typically include a provision within the Medicaid State plan that such payments will not exceed each qualifying hospital's DSH limit, such reimbursement methodologies do not identify cost components that are necessary for calculation of the hospital-specific DSH limits. Instead, States often for payment purposes rely on survey data reported by DSH hospitals to calculate hospital-specific DSH limit, data which is not typically audited by States to ensure compliance with the statutory limits on DSH payments.

While CMS recognizes that States must use estimates to determine DSH payments in a given Medicaid State plan rate year, Section 1923(j) of the Act requires confirmation that such payments do not exceed the cost limitations imposed by Congress under the Omnibus Budget Reconciliation Act of 1993.

Comment: A few commenters suggested the regulation should clarify the source for the information to be provided for the audit, particularly as it pertains to the payments made for the services. The commenters specifically asked whether the information should be on discharges during a State fiscal year (Medicare pays based on discharges), admissions during a State fiscal year (some States pay based on admissions), or actual payments made during the State fiscal year regardless of when the services were provided.

Response: Section 1923(j) of the Act requires states to report and audit hospital-specific DSH payments and hospital-specific uncompensated care costs. To meet this requirement, States must perform audits associated with defined periods of time and must identify the actual costs incurred and payments received during that defined time period.

As noted previously, we expect that States and auditors will obtain information whenever possible from existing sources. States and auditors should use consistent practices in their reports and audits. Because each State uses different hospital payment methodologies, there is no national rule on whether, for example, admissions or discharges should be used to measure whether services were furnished within a Medicaid State plan rate year. The same methodology should be used to measure uncompensated care costs as is used in determining payments under the Medicaid State plan.

CMS has developed a General DSH Audit and Reporting Protocol will be available on the CMS Web site to assist States and auditors in developing methodologies to use existing sources of information to determine uncompensated care costs in furnishing hospital services to the Medicaid and uninsured populations.

Comment: A few commenters stated they currently have no way of verifying payments to hospitals by Medicaid managed care organizations for inpatient and outpatient hospital services furnished to Medicaid eligible individuals because payments to hospitals are paid directly by the managed care plans. The commenters indicated that States have no first hand knowledge, and no claims documentation regarding these payments. The commenters questioned whether CMS would accept the use of self-reported hospital financial information that references these payments in total for purposes of the Annual DSH Reports.

Response: There are three specific types of revenues that must be included in the audit to which the State conducting the audit will not have direct access. They are: (1) Medicaid and DSH payments received by the hospital from a State other than the State in which the hospital is located; (2) Medicaid MCO payments; and, (3) uninsured payments. The State must rely on hospital audited financial statements and hospital accounting records for this information. The State's Medicaid Management Information System has the most central and current information for in-State Medicaid fee-for-service inpatient and outpatient hospital payments, Medicaid supplemental and enhanced payments and DSH payments and will be the source of such payment.

In addition, hospital cost information is available only from a reporting DSH hospital. The State and CMS must rely on hospital Medicare 2552-96 cost reports to provide this information.

Comment: One commenter requested CMS clarify that it is acceptable to report data for a recent prior period, with appropriate adjustments for expected changes between the data collection period and the DSH reporting period.

Response: We read the report and audit requirements to call for actual data, rather than estimated data. To accommodate the delays in obtaining data, we have extended the deadlines for submission of the reports and audits. While CMS recognizes that States must use estimates to determine initial DSH payments in a given Medicaid State plan rate year, Section 1923(j) of the Act requires confirmation that such payments do not exceed the cost limitations imposed by Congress under the Omnibus Budget Reconciliation Act of 1993. We do not believe estimates are sufficient to meet this requirement.

Comment: One commenter questioned the ramifications of reporting costs and payments in out-of-State and border hospitals, and asked whether the audit team would be responsible for DSH amounts for only hospitals in the State or for all hospitals (in State and out of State) that received Medicaid DSH dollars from that State. The commenter suggested that, in order to avoid duplicate payments, CMS should outline a methodology to be utilized when auditing hospitals that receive DSH payments from more than one State.

Response: A State is required to audit DSH payments and eligible uncompensated care costs for only those DSH hospitals that are located within the State. This method will allow the auditor to recognize DSH payments received by a hospital from other States in addition to the DSH payments received by that hospital under the "home-State's" approved Medicaid State plan.

For States that make DSH payments to hospitals located in other States, the State must include in the reporting requirements the DSH payments made to hospitals located outside of the State, but would not be required to audit those out-of-State DSH hospital's total DSH payments/total eligible uncompensated care costs. This method will ensure that no DSH hospital is audited more than one time per year for purposes of the DSH auditing and reporting requirements under the MMA.

Comment: Many commenters noted that the DSH program has allowed hospitals to extend access to healthcare for many poor and uninsured individuals. They noted that the new requirements include significant administrative expenses and responsibilities to both the States and hospitals. Several State Medicaid Agencies were concerned that a likely outcome will be that hospitals decline to participate in the DSH program, resulting in a decline in the delivery of healthcare services to the uninsured citizens and the patients treated from some Indian Reservations.

Response: CMS does not believe that the audit data burden will be significant since the audit relies on documents already available to hospitals. CMS also believes that it is unlikely a hospital will decline to receive Medicaid DSH payments for

uncompensated care simply because the hospital must provide information to the State to assist in the verification that DSH payments do not exceed the hospital's eligible uncompensated care costs as required by Federal law.

The State is responsible for the administration of its Medicaid program and the successful completion of the DSH audit as part of that administration. Costs associated with the audit are eligible for Federal administrative matching funds.

Comment: Many commenters stated it would be extremely labor intensive and an excessive reporting burden for (DSH) hospitals to match payments received from individuals to payments received for individuals for which there was no third party coverage because it does not currently do that automatically.

Response: To the extent that hospitals do not separately identify uncompensated care related to services provided to individuals with no source of third party coverage for the inpatient and outpatient hospital services they receive from uncompensated care costs not eligible under the hospital-specific DSH limits, hospitals will need to modify their accounting systems prospectively to do so. Setting up an accounting category to aggregate charges and revenues associated with uninsured individuals receiving inpatient and/or outpatient services from a hospital should be an accounting system adjustment not far removed from the process of setting up an account for any other payer category.

For purposes of the initial audits, States and auditors may need to develop methodologies to analyze current audited hospital financial statements and hospital accounting records to properly segregate uncompensated costs.

Comment: Many commenters have stated that it is unclear who must pay for the audit.

Response: The DSH audit and report is a necessary element in the administration of the Medicaid program. The cost of the audit is the responsibility of the State and can be matched by the Federal Government as a Medicaid administrative cost of the State.

Comment: Several commenters noted the proposed requirement for the independent certified audits is unduly burdensome. Several States have had in place for a number of years a requirement that hospitals submit certified public audit or certifications of hospitals' uncompensated care data. This is followed by the single State audit of State's DSH program which tests and verifies all of the elements that are currently required by the DSH state plan and State law requirements. To impose an additional layer of auditing at considerable expense to States is unnecessary.

Response: Section 1923(j) of the Act requires States to audit actual DSH payments made under the approved Medicaid State plan against actual eligible uncompensated hospital costs in the same time period. Hence, the audit requirement will necessarily measure whether payments made under the formulas in the approved Medicaid State plan are within the hospital-specific DSH payment limits as calculated by the State. The certification required in the regulation is a certification of the audit performed to determine compliance with the hospital-specific limitations imposed by Section 1923 of the Act.

While the DSH audit will rely on existing financial and cost reporting tools currently used by all hospitals participating in the Medicare program including audited hospital financial statements, hospital accounting records and the Medicare 2552-96 cost report, these source documents simply provide data to the auditor. Certification of these source documents is not sufficient to ensure that DSH payments do not exceed the hospital-specific limits and would not allow CMS to carry out the intent of the law which was to ensure that each DSH hospital will not exceed its hospital-specific limit. The independent certified audit will verify that the DSH payments authorized under the approved Medicaid State plan are within the hospital-specific DSH limits defined under Federal law.

Comment: Several commenters requested clarification regarding who is responsible for obtaining the independent audit and ensuring the requirements are met. For example, it could be presumed that these audit requirements are the responsibility of the State's auditor, the State Medicaid program's auditor, the Medicaid agency's staff or their agent, or the hospital's auditor.

A few commenters said it is not clear what constitutes "independent," and propose that CMS consider "independent audit" to mean an audit independent of the hospital that does not require the State to contract with a private-sector auditing firm to complete and certify. One commenter questioned whether the terms in the rule stating that the audit must be independent and certified presumes that a certified public accountant or comparable professional must perform the audit or is the State allowed to engage the services of a contractor with different skill sets as long as the auditor is independent? One commenter questioned whether "independent audit" means that a State may employ its current outside auditors to conduct audit and reporting requirements required by the proposed regulations, recognizing that audit programs will be modified to meet the additional auditing and reporting requirements demanded?

Response: The term "independent" means that the Single State Audit Agency or any other CPA firm that operates independently from either the Medicaid agency (or other agency making Medicaid payments) or the subject hospital(s) may perform the DSH audit. States may not rely on non-CPA firms, fiscal intermediaries, independent certification programs currently in place to audit uncompensated care costs, nor expand audits of hospital financial statements to obtain audit certification of the hospital-specific DSH limits.

Section 1923(j) of the Act requires States to report and audit specific payments and specific costs. The responsibility of the auditor is to measure DSH payments received by a hospital in a particular year against the eligible uncompensated care costs of that hospital in that same year. Certification means that the independent auditor engaged by the State reviews the criteria of the Federal audit regulation and completes the verification, calculations and report under the professional rules and generally accepted standards of audit practice. This certification would include a review of the State's audit protocol to ensure that the Federal regulation is satisfied, an opinion for each verification detailed in the regulation, a determination of whether or not the State made DSH payments that exceeded any hospital's specific DSH limit in the Medicaid State plan rate year under audit. The certification should also identify any data issues or other caveats that the auditor identifies as impacting the results of the audit.

Comment: Several commenters believe the most practical manner in which the State could meet this audit regulation is by requiring hospitals to have their uncompensated care data audited as part of their annual financial statement audit. Auditors of the Medicaid program (as part of the State's Single Audit) could then rely on these audited certifications and evaluate each State's DSH payment calculations and other information being reported by the State to the Secretary. Numerous commenters stated it would be more efficient and less burdensome for the individual hospitals to make the required verifications for their own financial data. Most hospitals already have their financial information reviewed and certified by an independent auditor, so the auditor could complete these verifications as part of the standard audit process. One commenter stated it is not clear if audit procedures applied in any other audits the hospital has undergone would be sufficient to rely upon in this verification. One commenter suggests that data submitted by a hospital which has had its own independent audit be considered "certified" for the independent audit requirements of this rule.

Response: States may not rely on independent certification programs currently in place to audit uncompensated care costs nor expand audits of hospital financial statements to obtain audit certification of the hospital-specific DSH limits. Section 1923(j) of the Act MMA imposes audit and reporting requirements on States. CMS must determine if all hospitals receiving DSH payments under the Medicaid State plan actually qualify to receive such payments and that actual DSH payments do not exceed the hospital-specific limit for the same period. The certification required in the regulation is a certification of the audit performed to determine compliance with Section 1923 of the Social Security Act.

While the DSH audit will rely on existing financial and cost reporting tools currently used by all hospitals participating in the Medicare program including audited hospital financial statements, hospital accounting records, and the Medicare 2552-96 hospital cost report, these source documents simply provide data to the auditor. Certification of source documents or uncompensated care cost programs is not sufficient to ensure that DSH payments do not exceed the hospital-specific limits and would not allow CMS to carry out the intent of the law which was to ensure that each DSH hospital will not exceed its hospital-specific limits.

Comment: Several commenters indicated that most of the requirements outlined in the proposed regulations require data that will be obtained from hospital cost reports. The commenters questioned whether the States will be responsible for completing individual hospital audits in greater detail prior to completing the DSH report. One commenter questioned whether having the data audited by an independent audit firm engaged by the DSH hospitals would satisfy the independent audit requirement, or whether States would be required to audit the data?

Response: We anticipate that the audit will rely primarily on already available documents. The State and auditors can use data extracted from existing hospital cost and financial reporting tools supplemented with State generated data from the State's Medicaid Management Information System. The data elements necessary for the State to complete the DSH audit and report should, in part, be information the State already gathers to administer the DSH program.

States and auditors will need to obtain data from hospitals and may need to work with hospitals to develop new data or methodologies to allocate or adjust existing data. And it may be necessary for auditors to develop methods to test, verify the accuracy of, and reconcile data from different sources. This audit function is not the same as the function of the hospital's own auditors, however, and would not involve a review of the hospital's financial controls and internal reporting procedures. But the auditors must review the overall methodology for accumulating data to ensure that the resulting data reflects the required elements. In other words, the independent auditors must review the methodology for arriving at hospital-specific data, and must have confidence that the data accurately represents the hospital's eligible uncompensated care costs consistent with the statutory criteria.

Comment: A few commenters indicated that many States have invested an increasing amount of time and expense managing Federal audits and presumed the increased audit requirements would be at the States' expense.

Response: CMS does not believe the audit data burden will be that significant since the audit may rely primarily on already available documents. The State and auditors can use data extracted from existing hospital cost and financial reporting tools supplemented with State generated data from the State's Medicaid Management Information System. The data elements necessary for the State to complete the DSH audit and report should, in part, be information the State already gathers to administer the DSH program. The State would incur additional cost associated with engaging an auditor but that cost is eligible for Federal administrative matching funds.

Comment: One commenter stated that using an independent auditor would add administrative costs to the Medicaid program. The State requests CMS to confirm if DSH funds can be used to fund the cost of the audit, and if the State can claim FFP at the DSH matching rate.

Response: State costs of the audit are administrative costs of the Medicaid program, and not DSH costs. The DSH program was established by Congress to help offset uncompensated inpatient and outpatient care provided by hospitals to Medicaid individuals and the uninsured. States may not access Federal DSH funding for purposes other than reimbursing hospitals for unreimbursed inpatient and outpatient services provided to Medicaid individuals and individuals with no source of third party coverage for the inpatient and outpatient hospital services they received.

The DSH audit and report is a necessary element in the administration of the Medicaid program. The State is responsible for the successful completion of the DSH audit as part of that administration. Costs associated with the audit are eligible for Federal administrative matching funds.

Comment: Numerous commenters noted that the proposed rule does not address how the audits will be paid for and there is a concern that the State Medicaid programs will pass on these additional costs to DSH hospitals. The commenters recommended that CMS state affirmatively that the cost of the audits should not be passed on to hospitals. A few commenters noted that since the cost of auditing each DSH hospital's records to satisfy the new audit requirements will be substantial and recommended it be funded by a special appropriation to the States for such purpose. Many commenters recommended that CMS reconsider its conclusion that the regulation would not have a significant economic impact and should undertake appropriate analyses under Executive Order 12866 and the regulatory impact analysis to consider how the burden on hospitals could be lessened.

Response: We still do not believe that this regulation will impose a significant impact. The final rule allows the DSH audits to be part of a hospital's existing annual financial. If this is the case, the costs to the hospital should be minimal since the annual hospital financial audit is already a requirement. States are responsible for the administration of their Medicaid programs and the successful completion of the DSH audit as part of that administration.

Comment: Numerous commenters indicated significant confusion regarding the mechanics of compliance with the requirement for States to have DSH payment programs independently audited annually and to submit those certifications annually to the DHHS Secretary. The commenters requested further guidance and explicit details of standards and procedures required by CMS.

Response: As a condition of continued Federal DSH funding, pursuant to Sec. 455.204, States will need to be in compliance with audit and reporting requirements. CMS has developed a General DSH Audit and Reporting Protocol which will be available on the CMS Web site to assist States and auditors in utilizing information from each source identified above and the methods under which costs and revenues will be determined. In addition, an auditing and reporting schedule is described in earlier responses to comments and is also included in the final regulation.

Comment: A few commenters noted that their States have experienced numerous difficulties when contracting with external auditing firms. Subjecting each hospital's DSH data to another audit at the State level would be an extremely time-consuming and very expensive process for the State would not add any value to the auditing process.

Response: The DSH audit and report is a necessary element in the administration of the Medicaid program. The State is responsible for the successful completion of the DSH audit as part of that administration. Costs associated with the audit are eligible for Federal administrative matching funds.

The term "independent" means that the Single State Audit Agency or any other CPA firm that operates independently from the Medicaid agency and the subject hospitals may perform the DSH audit. States may not rely on non-CPA firms, fiscal intermediaries

acting as agents for a State's Medicaid program, independent certification programs currently in place to audit uncompensated care costs, nor expand hospital financial statements to obtain audit certification of the hospital-specific DSH limits.

States may use Medicaid agency auditors to gather the data and perform initial data analysis for the DSH audit. However, the audit must be certified by an independent auditor as described above.

Comment: One commenter questioned whether it is CMS' intent to prevent an independent CPA firm, contracted by a State to audit Medicaid cost reports on the State's behalf, from being able to audit that same state's DSH program through the independence requirements of the Government Auditing Standards. If so, the commenter questioned if any contract with a State's Medicaid agency would impair the independence of a CPA firm in performing the DSH audit required in the rule.

Response: The intent of the requirement that States use independent auditors to certify the DSH audit is to provide a quality end product based on consistently applied auditing standards to produce unbiased findings. An independent auditor must operate independently from the Medicaid agency and the subject hospitals. The fact that a CPA firm contracts with the Medicaid agency to audit Medicaid cost reports does not disqualify that firm from being considered independent and therefore qualified to perform the DSH audit as long as the contract permits the auditor to exercise independent judgment.

Comment: Many commenters questioned whether the State audit agency would be appropriate for a certified independent audit according to generally accepted government auditing standards. If an independent audit of each facility is required, the commenters asked if State Medicaid program auditors would be considered independent to perform the hospital portion of the work.

Response: The term "independent" means that the Single State Audit Agency or any other CPA firm that operates independently from the Medicaid agency or subject hospitals is eligible to perform the DSH audit. States may not rely on non-CPA firms, fiscal intermediaries acting as Agents for a State's Medicaid program, independent certification programs currently in place to audit uncompensated care costs, nor expand hospital financial statements to obtain audit certification of the hospital-specific DSH limits.

States may use Medicaid agency auditors to gather the data and perform initial data analysis for the DSH audit. However, the audit must be certified by an independent auditor as described above.

Comment: A few commenters stated that the financial effectiveness of the audits would be enhanced if the Medicare fiscal intermediaries were available to do the audits. Intermediaries provide services at a lower cost than private accounting firms. Time would be saved because the intermediaries have all the necessary information. This may also be helpful to States that require a lengthy procurement bidding process.

Response: States may contract with Medicare fiscal intermediaries to the extent that the Medicare fiscal intermediary meets the definition of an independent CPA firm and operates under a contract that ensures independent judgment. The term "independent" means that the Single State Audit Agency or any other CPA firm operates independently from the Medicaid agency or subject hospitals.

Comment: One commenter questioned whether it would be appropriate for the State's Auditor General's office to perform the independent audit of DSH Payments using the Generally Accepted Government Auditing Standards.

Response: The term "independent" means that the Single State Audit Agency or any other CPA firm that operates independently from the Medicaid agency or subject hospital may be qualified to perform the DSH audit.

Generally Accepted Government Auditing Standards are the principles governing audits conducted of government organizations, programs activities, functions or funds. In general, government audits are either performance audits or financial audits. In either type, the focus is on the government entity, its management of a program and/or the financial management and reporting systems associated with that program.

The DSH audit and report is a necessary part of the administration of the Medicaid program. The purpose of the audit is to ensure that States make DSH payments under their Medicaid program that are in compliance with Section 1923 of the Act. The audit does not encompass the review of the State's overall Medicaid program, it simply ensures that one portion of the program is conducted in line with Federal statutory limits. In addition, the DSH audit will rely on financial and cost report data provided by hospitals that are subject to generally accepted accounting principles as part of their primary reporting function.

Comment: Many commenters expressed concern for the financial stability of disproportionate share hospitals and States and their requirement for finality, with respect to prior year DSH payment determinations. They asserted that allowing States to make good-

faith efforts to estimate hospital-specific DSH payment limits, so long as States are using the most recently available data, would help prevent situations in which States would need to attempt to take back past DSH payments to hospitals--a situation that would be especially burdensome for the very kinds of hospitals that DSH payments are intended to help. One commenter stated that the new rules impose an extremely heavy penalty on certain small hospitals. That commenter indicated that it would be unlikely that these hospitals could repay any amounts to the Medicaid program from current operating income.

Response: We recognize that States must use estimates to determine DSH payments in a given year. The regulation will provide information that will help ensure that the actual DSH payment made by States based on those estimates do not exceed the actual eligible uncompensated costs under the hospital-specific DSH limit. The transition period included in this regulation ensures that States will have time to adjust those estimates prospectively.

Comment: Numerous commenters did not see how the verification requirement could be completed without an additional annual cost report for an annual period that differs from its established fiscal year cost reporting period and an additional audit that would tie the hospital costs to the State year-end versus hospital year end and DSH payments with the same year actual uncompensated care costs. They asserted that the verification requirement is an extraordinary unreasonable and completely unnecessary administrative and economic burden on hospitals and States due to time-consuming, costly, and often duplicative audits. Many critical access hospitals do not have the excess manpower and resources to accomplish this additional audit. In many States, it disturbs an effective and efficient system that already meets Federal standards for program integrity.

Response: The DSH audit will rely on existing financial and cost reporting tools currently used by all hospitals participating in the Medicare program. We expect that State reports and audits will be based on the best available information. If audited Medicare cost reports are not available for each hospital, the DSH report and audit may need to be based on Medicare cost reports as filed. CMS does not believe that the audit data burden will be significant since the audit relies on documents already available to hospitals.

Comment: Many commenters noted that it would be an administrative burden to perform retrospective reviews and adjust each year's DSH payments. Therefore, the commenters request that CMS audit the data used by the State to determine the prospective DSH payments paid during the State fiscal year based upon the CMS approved DSH State plan payment methodology to determine the actual uncompensated care costs in the same audited SFY.

Response: Section 1923(j) of the Act imposes audit and reporting requirements on all States that make DSH payments to all DSH eligible hospitals within the State. As part of this process, CMS must determine if all hospitals receiving DSH payments under the Medicaid State plan actually qualify to receive such payments and that actual DSH payments made do not exceed the hospital-specific DSH limit for the same period.

DSH payments are limited by Federal law to each qualifying hospital's specific eligible uncompensated care cost in a given year. Auditing a State's DSH payment methodology will not ensure that DSH payments actually made by States do not exceed the statutorily required hospital-specific DSH limit. Verifying cost elements within a DSH payment methodology would not allow CMS to carry out the intent of the law which was to ensure that each DSH hospital will not exceed its hospital-specific DSH limit.

Comment: One commenter said Verification 3 would be a burden on the State. Another commenter stated that the requirements in Verification 3 would dictate significant additional work by the independent auditor (and added cost to the State and Federal governments) for unnecessary data analysis.

Response: CMS does not believe that Verification 3 in the regulation will create significant additional work for the independent auditor nor the States. The auditor engaged by a State to complete the DSH audit must rely on information provided by the State and DSH hospitals. This information will be based on existing financial and cost reporting tools as well as information provided by the State's Medicaid Management Information System and the existing approved Medicaid State plan. DSH hospitals must provide the State with hospital-specific cost and revenue data, including backup documentation, so that independent auditor may utilize in developing audit report. The State must provide the auditor with information pertaining to the Medicaid State plan DSH payment methodologies and the methodology utilized by the State uses to estimate the hospital-specific DSH limits.

CMS has developed a General DSH Audit and Reporting Protocol to provide guidance to States, DSH hospitals and auditors in the completion of the DSH audit. This Protocol includes general instructions regarding the types of information to be provided by hospitals to the State and its auditor as well as the calculations the auditor will make based on the data provided. The Protocol will be available on the CMS Web site.

The DSH audit and report is a necessary element in the administration of the Medicaid program. The cost of the audit is the responsibility of the State and can be matched by the Federal government as a Medicaid administrative cost of the State.

Comment: One commenter questioned whether it is CMS' intent that the term "appropriate" indicates documentation that has been verified and/or audited. The vagueness of the term may also make it difficult for an independent auditor to provide an opinion. As an alternative, and assuming that all other requirements will be clearly defined, the commenter recommends that CMS consider an alternative that a State employs a methodology for calculating the hospital-specific DSH limit that is permissible under Federal rules.

Response: The statutory process requires examination of whether all hospitals receiving DSH payments under the Medicaid State plan actually qualify to receive such payments and whether actual DSH payments made are within the hospital-specific DSH limit for the same period. DSH payments are limited by Federal law to each qualifying hospital's specific eligible uncompensated care cost limit. Several audits by the Inspector General have highlighted the need for greater scrutiny and have indicated that calculations performed by State agencies or hospitals are not reliable.

Concerning the degree of data verification required, States and auditors will need to obtain data from hospitals and may need to work with hospitals to develop new data or methodologies to allocate or adjust existing data. And it may be necessary for auditors to develop methods to test, verify the accuracy of, and reconcile data from different sources. This audit function is not the same as the function of the hospital's own auditors, however, and would not involve a review of the hospital's financial controls and internal reporting procedures. But the auditors must review the overall methodology for accumulating data to ensure that the resulting data reflects the required elements. In other words, the independent auditors must review the methodology for arriving at hospital-specific data, and must have confidence that the data accurately represents the hospital's eligible uncompensated care costs consistent with the statutory criteria.

Comment: A few commenters are concerned that the reporting requirements, as stated in the proposed regulation, suggest that there is only one way to calculate DSH payments and hospital-specific DSH payment limits when, in reality, Federal guidelines give States some leeway in making these calculations. The commenters are concerned that auditors will interpret their mandate very literally. One commenter said the State may find itself disagreeing with its auditor over the definitions of certain requirements and methodologies. Without additional CMS clarification, the auditor may revert to a reasonableness test when clarification is lacking, which may not meet the objectives of CMS in promulgating these rules.

Response: We agree that States may have some flexibility in interpreting the payment provisions under their State plan, and we expect that auditors will consult with the State agency on such interpretative issues. The calculation of the hospital-specific limits is less discretionary; DSH payments are limited by Federal law to each qualifying hospital's specific uncompensated care costs incurred in furnishing hospital services to the Medicaid and uninsured populations.

Comment: A few commenters said this rule would adversely affect access to health care for all children, not just Medicaid beneficiaries. Hospitals may be forced to close programs or clinics in order to cover revenue losses and access to care for all children, not just Medicaid beneficiaries would be limited. Children and their families would be forced to seek care in emergency rooms, which is a more expensive visit for Medicaid and will invariably result in ever more crowded emergency rooms.

Response: DSH payments are a way to provide additional funding to hospitals that serve a disproportionate share of low income patients, but the statute limits DSH payments to each hospital to the total uncompensated care costs in serving the Medicaid and uninsured populations. Since these limitations have been in place since 1993, CMS does not believe that any hospital could reasonably have relied on receiving funding above that level. CMS recognizes that States must use estimates to determine DSH payments in a given year. The information available through the reporting and auditing program under this regulation will assist States in ensuring that those estimates do not generate DSH payments that exceed the hospital-specific DSH limit.

Comment: One commenter believes the independent audit requirements should be included in the existing framework for audits of Federal programs under the Single Audit Act and include the five items requiring verification in the OMB Circular A-133 Compliance Supplement. One commenter suggested revision of OMB Circular A-133 Compliance Supplement to require the State Medicaid program's auditor test this reporting requirement by ensuring the Medicaid program received the information and audit assurances from the hospitals, accumulated the information, and properly reported the results to the Centers for Medicare and Medicaid Services.

Response: The DSH audit and report is a necessary element in the administration of the Medicaid program. The purpose of the audit is to ensure that States make DSH payments under their Medicaid program that are in compliance with Section 1923 of the Social Security Act. DSH payments are a small portion of a State's Medicaid program and the OMB Circular A-133 direction is far larger in scope than this audit.

It would be inappropriate to make the requested revisions to OMB Circular A-133 as OMB Circular A-133 specifically exempts Medicaid payments made by the State because these Medicaid payments are not considered to be "federal awards expended under this Section [Section 205, Basis for Determining Federal Awards Expended]". In addition, Subpart E also indicates that the scope of the A-133 Audit shall cover the entire operations of the auditee or a department, agency or other organizational unit.

It should be noted that the Single State Audit Agency qualifies as operating independently from the Medicaid Agency and, therefore, could perform the DSH audit albeit separate from the Single State Audit Act.

Comment: One commenter requests confirmation that the audit would be a Program Performance Audit of the State as defined in Government Auditing Standards, July 1999, Chapter 2, and as such would not require verification by a Certified Public Accounting firm as in the case of financial audits that lead to the expression of an opinion as defined in Chapter 3. One commenter noted that requiring the audits of the States to be performed under Generally Accepted Government Auditing Standards (GAGAS) will ensure that the reports are accurate and can be relied upon by third party users. One commenter stated that there are three sets of standards within GAGAS: Financial Audits, Attestation Engagements, and Performance Audits and questioned which set of standards would apply to the independent audit of DSH payments.

Response: The standards in GAGAS generally exceed the scope and objectives of the DSH audit and report. GAGAS rules govern the audits of government organizations, programs activities, functions or funds. In general, government audits are either performance audits, attestation engagements or financial audits.

In financial and performance audits, the focus is on the government entity, its management of a program and/or the financial management and reporting systems associated with that program. The DSH audit and report is a review of a segment of the Medicaid program and therefore does not fall within the scope of a performance or financial audit under GAGAS rules.

Attestation engagements may take a narrower focus (less than full program review) and, therefore, may seem to more directly fit with the scope of the DSH audit and report. However, attestation agreements under GAGAS rules include standards beyond non-governmental attestation agreements and these additional standards exceed the scope of the DSH audit and report.

The DSH audit and report is a necessary part of the administration of the Medicaid program. The purpose of the audit is to ensure that States make DSH payments under their Medicaid program that are in compliance with Section 1923 of the Social Security Act. The audit does not encompass the review of the State's Medicaid program, it simply ensures that one portion of the program is conducted in compliance with Federal statutory limits. In addition, the DSH audit will rely on financial and cost report data provided by hospitals that are subject to generally accepted accounting principles as part of their primary reporting function.

4. Section 1115 Demonstrations

Comment: One commenter believes the proposed rule as presently drafted will have a significant impact on hospitals if an exemption is not provided. The State has operated its DSH program for a number of years in strict accordance with the prescriptive terms negotiated between the State and CMS.

Response: The MMA imposes audit and reporting requirements on all States that make DSH payments. As part of this process, CMS must determine if all hospitals receiving DSH payments under the Medicaid State plan actually qualify to receive such payments and that actual DSH payments do not exceed the hospital-specific DHS limit for that same period. To the extent that a State makes DSH payments under a waiver demonstration, the State is not exempted from the rules surrounding DSH payments, particularly those at 1923(g) of the Act, and the audit and reporting requirements would still apply to that State.

Comment: Several commenters had questions regarding how States that operate their Medicaid programs under Federal waivers would do their Medicaid DSH reporting. The commenters suggest the regulation should specify that the DSH reporting and audit requirements do not apply to States that do not make DSH payments or are not required to comply with DSH requirements pursuant to Federal waivers of DSH requirements. The commenters urge CMS to exempt States with 1115 waivers from this rule if the waivers are based on certified public expenditures (CPEs) for Medicaid and DSH payments. One commenter stated that the recent implementation of the State's 1115 waiver completely changes the way DSH payments are calculated for the State's hospitals, therefore, this audit requirement would be duplicative.

Response: These DSH audit and reporting requirements apply to States with Section 1115 demonstrations to the extent that the waiver list associated with the demonstration does not explicitly waive the State from compliance with Section 1923 of the Act. The DSH audit and reporting time frames for States with DSH programs and Section 1115 demonstrations are subject to the same time frames as those States without 1115 demonstrations. The only exception would be if a State has a demonstration project under

Section 1115 that includes a waiver of the requirements of Section 1923 so that the State does not make Medicaid DSH payments at all. In that instance, since there are no DSH payments, the DSH audit and reporting requirements would not apply.

5. Time Period Subject to DSH Audit and Report

Comment: One commenter asked for clarification of the treatment of DSH payments when a State makes a portion of the fiscal year's DSH payments after the end of its fiscal year. One commenter asked whether, when DSH payments are made on an accrual accounting basis and adjusted after the report has been filed, whether the State must file a corrected report. Several commenters indicated that dissatisfied hospitals have the ability to appeal their payments, a process that could extend the period of time before the final payment is known. They asked how to report regular Medicaid rate payments that are not known at the end of any given State fiscal year. One commenter said that many States allow Medicaid providers up to a year to submit claims following the date of service. As such, the commenter indicated that there is often a significant lag in payments to Medicaid hospitals and uncompensated care figures would be overstated if only cost incurred and payments received during a SFY are considered.

Response: Since the deadline for reporting the audit findings has been extended to at least three full years after the close of the Medicaid State plan rate year subject to audit, hospitals would have received all Medicaid and DSH payments associated with that Medicaid State plan rate year. This two-year period accommodates the one-year concern expressed in many comments regarding claim lags and is consistent with the varying hospital cost reporting periods and adjustments and accommodates DSH payments made from different allotment years.

It should be noted that, to the extent that a State makes a retroactive adjustment to non-DSH payments after the completion of the audit for that particular Medicaid State plan rate year, the hospital would necessarily have received and booked the revenues in a subsequent Medicaid State plan rate year. Under these circumstances, the revenue adjustments would be measured during the audit of the Medicaid State plan rate year in which the revenues were received.

The treatment of post-audit Medicaid payments, including regular Medicaid rate payments, supplemental and enhanced payments, Medicaid managed care payments, DSH, and "self-pay" revenues and other collections including liens would be treated as revenues applicable to the Medicaid State plan rate year in which they are received.

Comment: Several commenters noted that the State is required to indicate the Medicaid Managed Care Organization Payments paid to the hospital for the SFY being reported. Claims may be submitted to the Medicaid Managed Care Organization (MCO) for payment up to one year after the date of service. Therefore, payments made by the MCO for claims with date of service in the SFY may be submitted up to a year after the service date by the hospital. The payments would not be available before 12 months after the SFY at a minimum. Obtaining the amount paid by the MCO for the SFY being reported is not possible by the end of the SFY.

Response: Based on the modifications to the audit and reporting deadlines and the Medicaid two-year timely filing claim limit, there should not be a significant adjustment to Medicaid payments that would warrant a corrected report. To the extent that such an adjustment to Medicaid payments occurs, no corrected audit or report is necessary. To the extent that a State makes a retroactive adjustment to non-DSH payments after the completion of the audit for that particular Medicaid State plan rate year, the hospital would necessarily have received and booked the revenues in a subsequent Medicaid State plan rate year. Under these circumstances, the revenue adjustments would be measured during the audit of the Medicaid State plan rate year in which the revenues were received.

6. Verification I--Proper Reduction to Uncompensated Care Cost

Comment: Several commenters believe that different parts of the regulation define "uncompensated care costs" differently, and they should be modified and made consistent. The commenters provided suggested changes in an effort to eliminate a contradiction between the definitions, contained in Sec. Sec. 447.299(c)(15) and 455.204(c). Several commenters believe that Verification 1 requires each hospital receiving DSH payments reduce its uncompensated care costs by the amount of DSH payments received in any given year. The commenters argued that the statute clearly defines the DSH limit so that DSH payments should not be offset against the hospital specific limits. They noted that the language of Section 1923(j) only requires the auditors to verify "the extent to which" the costs have been reduced. Thus, if costs have not been reduced at all, the auditor would verify that fact and the audit requirement would be met. The regulatory language should be revised to be consistent with the statutory requirement. Other commenters stated that the proposed rule requires an audit verification that each disproportionate share hospital in the State has reduced its uncompensated care costs in order to reflect the total amount of claimed DSH expenditures. They are not clear how a hospital can demonstrate this, as costs generally are not reduced by expenditures. One commenter recognizes that CMS likely based its formulation of the verification requirement on the statutory language, which contains similarly confusing terminology, requiring the audit to verify "the extent to which hospitals in the State have reduced their uncompensated care costs to reflect the

total amount of claimed expenditures made under [the Medicaid DSH statute]." The commenter suggests that a more useful interpretation of this statutory language would be to require verification that DSH payments have not exceeded uncompensated care costs.

Response: The purpose of the statute is for States to audit actual DSH payments made under the approved Medicaid State plan against actual eligible uncompensated hospital costs for the same time period. In reviewing the meaning of the statutory language, we have determined that verification 1 is designed to ensure that hospitals are able to fully retain the DSH payments made to them for the uncompensated cost of providing inpatient and outpatient hospital services to Medicaid beneficiaries and individuals with no source of third party coverage net of all Medicaid payments received and payments by or on behalf of individuals with no source of third party coverage for the services they received. We have revised the regulation text to make this clearer.

7. Verification 2--Calculation of Eligible Uncompensated Care Cost, Prospective Estimates Versus Reconciled Cost

Comment: Many commenters indicated that for States that determine the individual hospital DSH limit prospectively, the one-year filing requirement may be attainable (at least after these rules take effect) if the requirement is only to validate the accuracy of the prospective calculation. But for those States that do base the determination on current year costs, a report based on a final audit of hospital cost reports could not be submitted within one year. Final settlement of hospitals' cost reports is typically contingent upon completion by a Medicare intermediary of audits--a process that can take several years. CMS should allow these States additional time to submit the audit certifications, so these certifications can be based on the final settled cost report. Alternatively, CMS could clarify the rule to permit the required report to be based on a hospital's as-filed cost report. If necessary, there could be later reconciling adjustment after the cost report is finally settled and an audit certification can be made.

Response: CMS recognizes that States may need to use estimates to determine DSH payments made by States to individual qualifying hospitals in an upcoming Medicaid State plan rate year. Section 1923(j) of the Act requires States to report and audit hospital-specific DSH payments and hospital-specific uncompensated care costs. To meet this requirement, States must perform audits associated with defined periods of time and must identify the actual costs incurred and payments received during that defined time period. To respond to comments on the practicality of audit timing, we have modified the time frame for the audit and reporting requirements as discussed above. We also note that we expect that reports and audits will be based on the best available information. If audited Medicare cost reports are not available, the DSH report and audit may need to be based on Medicare cost reports as filed.

Comment: Numerous States indicated that if the audit requirement is simply to verify the manner in which the DSH limit was applied prospectively, the one-year timeline may be realistic for years subsequent to the adoption of a final regulation for States using prospective methods, and hospitals with fiscal years different than the State's should not present as much of a concern, because the prospectively determined limit would have been calculated based on cost reports for earlier time periods. Accordingly, the commenters request that CMS clarify that the proposed regulations are not intended to disturb the use of prospective calculations to apply the individual hospital DSH limit.

Response: This regulation is not intended to require States to implement retrospective DSH methodologies. CMS recognizes that States may need to use estimates to determine DSH payments in an upcoming Medicaid State plan rate year. However, Section 1923(j) of the Act requires confirmation that DSH payments made by States to individual qualifying hospitals do not exceed the actual cost limitation imposed by Congress.

Based on the revisions to the auditing and reporting timeframes, which, in part, requires the Medicaid State Plan rate year 2005 and 2006 audits to be completed no later than the last day of Federal fiscal year 2009, it is feasible for the audit to measure eligible uncompensated care costs incurred against the DSH payments received in a given time frame. The transition period included in the final regulation ensures that States may adjust those estimates prospectively to avoid any immediate adverse fiscal impact and to ensure that future DSH payments do not exceed the hospital-specific DSH limits.

Comment: Several commenters noted that there is no current law requiring that DSH payments made in a fiscal year correspond to costs from that same fiscal year. In addition, CMS has never before imposed a reconciliation requirement. A few commenters stated Section 1923(g) of the Act does not require that the OBRA 1993 limits be recalculated and reapplied to reflect subsequently available year-of-service data.

Response: Section 1923(j) of the Act requires States to report and audit specific payments and specific costs. These reports must assess compliance with the statutory hospital-specific limitations on the level of DSH payments to which qualifying hospitals were entitled. Section 1923(g)(1)(A) specifies that DSH payments cannot exceed, "the costs incurred during the year of furnishing hospital

services (as determined by the Secretary and net of payments under this title, other than under this Section, and by uninsured patients * * *"). The goal of the regulation is to audit DSH payments made under the authority of the Medicaid State plan and to ensure that States do not make DSH payments that exceed the hospital-specific cost limit defined under the Omnibus Budget Reconciliation Act of 1993.

CMS recognizes that States may need to use estimates to determine DSH payments in an upcoming Medicaid State plan rate year. However, the statute requires confirmation that DSH payments do not exceed the actual cost limitation imposed by Congress.

Comment: Numerous commenters stated that the DSH reporting and auditing requirements contained in MMA were intended only to ensure compliance with the DSH requirements, not to change the DSH requirements themselves. They asserted that nothing in the statute either requires or encourages a change in CMS's longstanding policy that DSH payments can be based on a prospective estimate of a hospital's uncompensated care costs. They argued that the statute does not require that payments be based on actual audited costs and nothing in the statute requires CMS to impose this dramatic shift in policy. This approach allows for adjustment during future years for reconciling DSH payments to actual costs. Numerous commenters said that CMS has always acknowledged that the law permits States to base their DSH payments on a prospective estimate of a hospital's uncompensated care costs for a given year, derived from the hospital's costs in prior years, and many if not most States utilize this approach. A few commenters noted that CMS has allowed States flexibility to use estimates of current year uncompensated costs. One commenter stated the statute provides that a DSH payment adjustment "during a fiscal year" is considered non-compliant with the limit if the adjustment exceeds the uncompensated costs for Medicaid and uninsured patients incurred "during the year" and that CMS appears to be basing this burdensome reconciliation requirement solely on this language. The commenter believes that while the provision does limit current year payments to current year costs, nothing in the language mandates the use of actual audited costs. Indeed, the commenter indicated that reliable estimates based on audited prior year data will produce sufficient controls on the DSH payments and fulfill Congress' intent of limiting DSH expenditures on a hospital-specific basis.

Response: Section 1923(g)(1)(A) of the Act specifies that DSH payments cannot exceed, "the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this Section, and by uninsured patients * * *"). The goal of the regulation is to audit DSH payments made under the authority of the Medicaid State plan and to ensure that States do not make DSH payments that exceed the hospital-specific cost limit defined under the Omnibus Budget Reconciliation Act of 1993.

Section 1923(j) of the Act expressly requires States to report and audit specific payments and specific costs. As part of this process, CMS must obtain all information necessary to determine if all hospitals receiving DSH payments under the authority of the approved Medicaid State plan actually qualify to receive such payments and that actual DSH payments made by States do not exceed the hospital-specific limit for the same period. DSH payments are limited by Federal law to each qualifying hospital's specific eligible uncompensated care cost limit.

CMS recognizes that States may need to use estimates to determine DSH payments in an upcoming Medicaid State plan rate year. However, the statute requires confirmation that DSH payments do not exceed the actual cost limitation imposed by Congress. CMS has modified the regulation to include a transition period to ensure that States may adjust those estimates prospectively to avoid any immediate adverse fiscal impact and to ensure that future DSH payments do not exceed the hospital-specific DSH limits.

Auditing actual payments made in a given year against estimated hospital uncompensated care costs in that same year would not ensure that DSH payments did not exceed actual uncompensated care costs. Several Inspector General audits attest to the discrepancies in the results. In fact, measuring the difference between DSH payments and estimates of uncompensated care costs would never produce a true determination of whether or not DSH payments in a given year exceeded the Congressionally defined cost limit for that year.

Comment: Numerous commenters indicated that States cannot determine the actual uncompensated care costs prior to or during the year that DSH payments are made. The commenters stated that this could prevent States from making prospective estimates of Medicaid shortfalls and uninsured costs. The commenters recommend that States be allowed to continue to utilize historical information to perform prospective DSH limit calculations.

Response: CMS recognizes that States may need to use estimates to determine DSH payments in an upcoming Medicaid State plan rate year. However, CMS does not have authority to authorize payments that exceed statutory hospital-specific limits and those limits are based on actual uncompensated care costs. The goal of the regulation is to audit DSH payments made under the authority of the Medicaid State plan and to ensure that States do not make DSH payments that exceed those statutory hospital-specific cost limits. The information necessary for such confirmation is readily available to hospitals and the State based on existing financial and cost reporting tools.

Comment: Many commenters noted that the proposed methodology would be inconsistent with their approved Medicaid State plan and conflicts with past CMS guidance and practice. They indicate that a retrospective audit to determine the accuracy of the estimates used to determine uncompensated care costs based on the approved prospective methodology would require changing the State plan. They ask how this audit should be conducted by States that already have CMS approval for use of prospective methodologies, not to mention that a retroactive audit could significantly affect already approved programs.

Response: This regulation is not intended to require States to implement retrospective DSH methodologies. CMS recognizes that States may need to use estimates to determine DSH payments in an upcoming Medicaid State plan rate year. However, CMS cannot authorize DSH payments that exceed the limitations imposed by Congress. States will have to determine how to best ensure that prospective DSH methodologies do not result in payments that exceed those limitations, either by revising those methodologies or by providing for reconciliation of prospective payments with those limits. CMS as always is available to offer technical assistance to States in developing such methodologies.

CMS has modified the regulation to include a transition period to ensure that States may adjust prospective estimates to avoid any immediate adverse fiscal impact.

8. Fiscal Impact--Effect on Federal Financial Participation

Comment: A few commenters questioned whether CMS will withhold Federal Financial Participation from the States until its Independent Audit of DSH Payments is completed and filed with CMS.

Response: The final regulation defines the time periods applicable to the auditing and reporting of DSH payments. These deadlines provide sufficient time for States to comply with the statute. The final regulation also provides that Federal financial participation for DSH payments is not available to any State that has not submitted its required audits and reports.

Comment: A few commenters said that the proposed regulation states the penalty for failure to provide the required information by the stipulated deadline but does not address the question of whether or not CMS will require States to return DSH funds if the information collected is unsatisfactory to CMS.

Response: The goal of the regulation is to audit DSH payments made under the authority of the Medicaid State plan and to ensure that States do not make DSH payments that exceed the hospital-specific cost limit defined in Section 1923(g) of the Act. CMS has modified the regulation to include a transition period to ensure that States have an opportunity to refine audit and reporting practices and determine the impact on the State DSH methodologies. The final regulation provides that Federal financial participation for DSH payments is not available to any State that has not submitted its required audits and reports. However, CMS intends to work with States to ensure that the audits and reports meet all statutory and regulatory requirements.

Comment: A few commenters asked for clarification on the actions that may be taken against States if States are not found to be in compliance with all verifications required as part of the audit (Sec. 455.204(c)).

Response: The final regulation defines the time periods applicable to the auditing and reporting of DSH payments. These deadlines provide sufficient time for States to comply with the statute. The final regulation also provides that Federal financial participation in DSH payments is not available to any State that has not submitted its required audits and reports. As mentioned above, CMS intends to work with States to ensure that the audits and reports meet all statutory and regulatory requirements.

Comment: A few commenters said the proposed regulation is silent on the question of post-audit adjustments. In some cases, audits will reveal actual costs that were not included in the estimated uncompensated care costs provided. In such cases, provided there are funds remaining in the State's DSH allotment or other money available for such purposes, the commenters recommended that States should be permitted to compensate hospitals.

Response: CMS has modified the regulation to lengthen the time frame for preparation of the required report and audit, and to include a transition period to ensure that States have time to refine their audit processes. The instance of post audit adjustments will be significantly lessened as a result.

9. Verification Three--Data Sources Used in Calculation of Eligible Uncompensated Care Costs

Comment: Many commenters requested clarity on the mechanics of reconciliation. Although the MMA requires an annual certified public audit, the proposed rule is unclear about how the audit will reconcile DSH payments and the hospitals' calculation of actual

compensated care. Hospitals submit accurate data on Medicaid and uncompensated care at a point in time. Data can change over time as claims and payment appeals are settled.

Response: We believe that the three-year period allotted for completion of the audit accommodates these concerns. Sufficient time is available to ensure that necessary cost reports and other financial data are available to make these determinations. This accommodates the concern expressed in many comments regarding claims lags and is consistent with the varying hospital cost report periods and adjustments. CMS has developed a General DSH Audit and Reporting Protocol to provide guidance to States, DSH hospitals and auditors in the completion of the DSH audit. This protocol provides general instructions regarding the calculations the auditor will make based on the data provided.

10. Verification Four--Proper Accounting of Medicaid and Uninsured Revenues

Comment: A few commenters noted that the audit and reporting requirements are unnecessary in several States where the federal DSH allocation to the States has consistently fallen short of the State's aggregate DSH limit by at least \$200 million in each of the past five years.

Response: The Statewide aggregate DSH allotment is only one of the limitations on DSH payments. The audit and reporting requirements also concern hospital-specific limitations, which involve review of specific payments and specific costs by individual hospital. The goal of the audit and report is to ensure that DSH payments made by States under the authority of the approved Medicaid State plan do not exceed the hospital-specific uncompensated care cost limit as required by Section 1923(g) of the Act. Irrespective of a State's aggregate DSH allotment, or overall levels of uncompensated care, a DSH hospital may not receive more in DSH payments than the individual hospital's eligible uncompensated care costs.

Comment: A few commenters stated that the financial exposure for the Federal government through the use of estimated rather than reconciled data is not significant, as total DSH expenditures are limited by the Statewide DSH allotment. The benefit obtained through the reconciliation mandate is therefore far outweighed by its costs.

Response: As discussed above, the Statewide DSH allotment and hospital-specific limitations are separate and distinct. Section 1923(g)(1)(A) of the Act specifies that DSH payments cannot exceed, "the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this Section, and by uninsured patients * * *)". Section 1923(j) of the Act and this regulation require States to audit DSH payments made under the authority of the Medicaid State plan and to ensure that States do not make DSH payments that exceed this hospital-specific cost limit.

The data elements necessary for the State to complete the DSH audit and report should, in part, be information the State already gathers to administer the DSH program. Thus, CMS believes that the burden on the State will not be substantial. The State will have some additional cost associated with engaging an auditor but that cost is eligible for Federal administrative matching funds.

Comment: Numerous commenters expressed concern about the proposed rule because adoption would greatly reduce the DSH payments to hospitals. Such a reduction would eliminate some of the future services hospitals provide. The largest burden would be on the impoverished communities since many of those people could not travel to receive those services elsewhere.

Response: Hospitals should not realize a significant reduction in DSH payments based on the audit and reporting requirements. Moreover, any reduction would simply be the result of ensuring that limited State DSH funds are used appropriately and meet the requirements of the Medicaid statute. This rule will help to ensure that Medicaid DSH payments appropriately recognize allowable unreimbursed Medicaid and uninsured uncompensated care costs. The DSH law was enacted to recognize needs of hospitals that serve a disproportionate number of Medicaid and low-income patients. In 1993, Congress imposed hospital-specific limitations on the level of DSH payments to which qualifying hospitals were entitled. Section 1923(g)(1)(A) specifies that DSH payments cannot exceed, "the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this Section, and by uninsured patients * * *)". Congress clearly identified the DSH limit as specific to the costs incurred for providing certain hospital services to Medicaid individuals and individuals with no source of third party coverage.

Comment: Several commenters expressed concern that the results of audits may be used to attempt to take back money from States and/or hospitals for failing to meet standards that they never knew existed, long after hospital's fiscal year is over. If the State would be required to return DSH money to the Federal Government, this would necessitate the return of DSH money to the State by hospitals. This would be extremely burdensome for hospitals, which undoubtedly would already have spent that money serving their

low-income and uninsured patients. One commenter said that after-the-fact exposure is untenable for States with balanced budget requirements.

Response: CMS has modified the regulation to include a transition period to ensure that States may adjust uncompensated care estimates prospectively to avoid any immediate adverse fiscal impact and to assist States in ensuring that future DSH payments do not exceed the hospital-specific DSH limit. To permit States an opportunity to develop and refine audit procedures, audit findings from Medicaid State plan rate year 2005-2010 will be limited to use for the purpose of estimating prospective hospital-specific uncompensated care cost limits in order to make actual DSH payments in the upcoming Medicaid State plan rate years. CMS is not requiring retroactive collection for Medicaid State plan rate years that have already passed. By using that time to improve State DSH payment methodologies, States may avoid circumstances in which DSH payments that exceed Federal statutory limits must be recouped from hospitals. CMS will also be available to provide necessary technical assistance to States to ensure proper implementation of these requirements.

Comment: One commenter said that their State plan permitted DSH payments to DSH-eligible, out-of-State hospitals that service the State's Medicaid recipients. The commenter requested clarity regarding the State's responsibility in terms of hospital-specific DSH limit calculations and auditing and reporting requirements insofar as these out-of-State hospitals are concerned.

Response: A State is required to audit payments and costs for only those DSH hospitals that are located within the State. This method will allow the auditor to recognize DSH payments received from other States in addition to the DSH payments received by that hospital under the "home-State's" approved Medicaid State plan.

For States that make DSH payments to hospitals in other States, the State must include in the reporting requirements the DSH payments made to hospitals located outside of the State but would not be required to audit those out-of-State DSH hospital's total DSH payments/total eligible uncompensated care costs. This method will ensure that no DSH hospital is audited more than one time per year for purposes of the DSH auditing and reporting requirements under Section 1923(j) of the Act.

Comment: A few commenters asked whether CMS will require States to include in the report information on patients from another State.

Response: The goal of the audit and report is to ensure that DSH payments made by States under the authority of the approved Medicaid State plan do not exceed the hospital-specific cost limit. In order to do this, all applicable revenues must be offset against all eligible costs. For purposes of determining the hospital-specific DSH limit, revenues would include all Medicaid payments made to hospitals for providing inpatient and outpatient hospital services to Medicaid individuals (irrespective of the State in which the individual is eligible) and all payments made by or on behalf of patients with no source of third party coverage for the inpatient and outpatient hospital services they received. For purposes of the DSH audit and to determine whether hospital-specific cost limits have been exceeded, all DSH payments made by States and received by a hospital would need to be offset against the determined eligible uncompensated care cost limit.

Any Medicaid payments received by a hospital from any Medicaid agency (in state or out of state) should be counted as revenue offsets against total incurred Medicaid costs. Any DSH payments received by a hospital from any Medicaid agency (in state or out of state) must be counted as an offset against uncompensated care for purposes of the DSH audit and ensuring that the hospital-specific DSH limit is not exceeded.

Comment: One commenter requested instructions for reporting information to CMS related to DSH payments on an annual basis. Annual reporting requirements also contain specific reporting requirements related to DSH payments. The commenter asked for clarification as to whether the proposed rules supersede the reporting requirements detailed in the March 26, 2004, Federal Register Notice [CMS-2062-N].

Response: All DSH reporting requirements published under CMS-2062-N are superseded by Section 1923(j) of the Act and this implementing regulation.

Comment: A few commenters noted the proposed Sec. 447.299(c)(8) incorrectly refers to Section 1923(g) instead of referring to the entire Section 1923.

Response: The regulation has been modified to reflect the correct statutory citation.

Comment: A few commenters noted that the Reporting form was not included with the proposed rules and requested a copy of the example Reporting form.

Response: A modified Reporting form is included in this regulation.

Comment: One commenter noted that in FY 2003, total Federal DSH allotments to States totaled just under \$9 billion. The commenter requests copies of any audit findings and/or programs associated with CMS' historic and ongoing efforts to audit and/or verify the figures used by States to justify Federal funds.

Response: The commenter may request information consistent with the authority of the Freedom of Information Act.

Comment: One commenter noted CMS has not pointed to any systematic findings that call into question the reasonableness of approved methodologies.

Response: The statutory authority under MMA instructed States to report and audit specific payments and specific costs. This rule does not call into question the reasonableness of approved methodologies; it simply implements the statutory reporting and auditing requirements to determine whether DSH payments were proper with respect to the specific DSH hospitals that were paid.

IV. Changes to the Proposed Rule

As explained in our responses to comments, we have made the following revisions to the DSH Auditing and Reporting regulations published in the August 26, 2005 Proposed Rule:

A. Reporting Requirements

1. Audit Year and Submission Dates Defined

CMS has modified the regulation at Sec. 447.299(c) to address concerns regarding the inability to complete the audit and report within a year from the end of SFY 2005. The regulation has been modified to identify the Medicaid State plan rate year 2005 as the first time period subject to the audit. The basis for this modification is recognition of varying fiscal periods between hospitals and States. The Medicaid State plan rate year is the one uniform time period under which all States must estimate uncompensated costs in order to make DSH payments under the approved Medicaid State plan. The regulation has also been modified to identify that each audit report must be submitted to CMS within 90 days of the completion of the independent certified audit. The reports associated with Medicaid State plan rate years 2005 and 2006 are due no later than December 31, 2009. Each subsequent audit report is due no later than December 31st of the FFY ending three years after the Medicaid State plan rate year under audit.

2. Report Data Elements

CMS has modified the regulation at Sec. 447.299(c) to address many comments concerning the necessary data elements to fulfill the audit and reporting requirements. Specifically, the regulation has been modified to remove the following data elements:

1. Medicare provider number.
2. Medicaid provider number.
3. Type of hospital.
4. Type of hospital ownership.
5. Transfers.
6. Medicaid eligible and uninsured individuals.

In addition, the regulation at Sec. 447.299(c) has been modified to add or clarify the following data elements which are necessary to fulfill the auditing and reporting requirements:

1. Identification of facilities that are Institutes for Mental Disease (IMD) receiving DSH payments;
2. Identification of out-of-state hospitals receiving DSH payments;
3. State estimate of hospital-specific DSH limit;
4. Medicaid inpatient utilization rate (if applicable);
5. Low-income utilization rate (if applicable);
6. State-defined DSH eligibility statistic (if applicable);
7. Total inpatient and outpatient Medicaid payments;
8. Total inpatient and outpatient Medicaid cost of care;

9. Total Medicaid inpatient and outpatient uncompensated care;
10. Total inpatient and outpatient uninsured and self-pay revenues;
11. Total applicable Section 1011 payments received by the hospital;
12. Total inpatient and outpatient uninsured cost of care;
13. Total inpatient and outpatient uninsured uncompensated care;
14. Total eligible inpatient and outpatient uncompensated care.

The Reporting form has also been modified to reflect these modifications.

B. Audit Requirements

1. Definitions

CMS has modified the regulation at Sec. 455.201 to clarify the definition of independent certified audit to mean that the Single State Audit Agency or any other CPE firm that operates independently from the Medicaid agency is eligible to perform the DSH audit and to define Medicaid State plan rate year as the time period subject to the audit. The definition of State fiscal year has been removed.

2. Certified Independent Audit Requirements

Based on many comments regarding the potential immediate adverse fiscal impact of the DSH audit on States, CMS has modified the regulation at Sec. 455.204(a) to indicate conditions related to the audit that States must meet in order to receive Federal disproportionate share hospital payments. A transition period related to audit findings for Medicaid State plan rate year 2005 through 2010 is included in this Section. Instructions regarding audit findings and their applicability to Medicaid State plan rate year 2011 forward are also included. The modifications are as follows:

Transition period. Findings of the 2005 and 2006 Medicaid State plan rate year audit and report will be available to States during their SFY 2010. These findings must be taken into consideration for Medicaid State plan rate year 2011 uncompensated care cost estimates and associated DSH payments.

Audit findings associated with Medicaid State plan rate years 2007 through 2010 must be similarly considered for Medicaid State plan rate years 2012 through 2015. Findings from Medicaid State plan rate year 2005-2010 will be used only for the purpose of determining prospective hospital-specific eligible uncompensated care cost limits and associated DSH payments.

DSH payments that exceed the hospital-specific eligible uncompensated care cost limit related to Medicaid State plan rate year 2011 must be returned to the Federal government or redistributed by States to other qualifying hospitals.

In response to many public comments regarding the inability of States to complete the audit within one year of the end of the State fiscal year, CMS has modified the regulation at Sec. 455.204(b) to indicate a new time period for the submission of the independent certified audit. The new time period is as follows:

Identify that the Medicaid State plan rate year 2005 and 2006 audits must be completed no later than the last day of Federal fiscal year 2009. Each subsequent audit beginning with Medicaid State plan rate year 2007 must be completed by the last day of the Federal fiscal year ending three years from the Medicaid State plan rate year under audit. Therefore, for the 2007 Medicaid State plan rate year, the audit must be completed by the last day of Federal fiscal year 2010.

The regulation was modified at 455.204(c) to include a new Section identifying the primary sources and source documents from which States will draw data necessary to complete the independent certified audit. These documents are identified as:

The approved Medicaid State plan for the State plan rate year under audit.

State Medicaid Management Information System payment and utilization data.

The Medicare 2552-96 cost report or subsequent Medicare defined hospital cost report tool.

DSH hospital audited financial statements and hospital accounting records.

The regulation was modified to redesignate Sec. 455.204(c) as Sec. 455.204(d) (1) through (6) to accommodate the new Sec. 455.204(c).

In addition, CMS developed a General DSH Auditing and Reporting Protocol to provide States with guidance on the completion of the DSH Audit and Report. This protocol will be available on the CMS Web site.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 30-day notice in the Federal Register and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

The need for the information collection and its usefulness in carrying out the proper functions of our agency.

The accuracy of our estimate of the information collection burden.

The quality, utility, and clarity of the information to be collected.

Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Therefore, we are soliciting public comment on each of these issues for the following information collection requirements discussed below.

Section 447.299 Reporting Requirements

Paragraph (c) of this Section requires the States to submit to CMS information for each DSH for the most recently-completed fiscal year beginning with the first full State fiscal year (SFY) after the enactment of Section 1001(d) of the MMA, which for all States will begin with their respective SFY 2005 and each subsequent SFY. This paragraph presents the information to be submitted.

The burden associated with this requirement is the time and effort for the States to prepare and submit the required information. We estimate that it will take each State approximately 30 minutes to prepare and submit the information for each of its DSHs. On average, each State has approximately 75 DSHs. Therefore, we estimate it will take 38 hours per State to comply for a total of 1,976 annual hours. The burden for this requirement is currently approved under OMB 0938-0746 with an expiration date of August 31, 2011.

Section 455.204 Condition for Federal Financial Participation

In summary, this Section states what information must be included in the audit report and submitted to CMS.

The PRA exempts the information collection activities referenced in this Section. In particular, 5 CFR 1320.4 excludes collection activities during the conduct of administrative actions, investigations, or audits involving an agency against specific individuals or entities.

As required by Section 3504(h) of the Paperwork Reduction Act of 1995, we have submitted a copy of this final regulation to OMB for its review of these information collection requirements described above.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attn.: Melissa Musotto, CMS-2198-F, Room C5-14-03, 7500 Security Boulevard, Baltimore, MD 21244-1850.

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn.: Katherine T. Astrich, CMS Desk Officer, CMS-2198-F, Katherine.T.Astrich@omb.eop.gov. Fax (202) 395-6974.

VI. Regulatory Impact Analysis

We have examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), Section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), and Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866, as amended, directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). This rule does not reach the economic threshold and thus is not considered a major rule.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of \$7 million to \$34.5 million in any 1 year. Individuals and States are not included in the definition of a small entity. We are not preparing an analysis for the RFA because the Secretary has determined and we certify that this rule would not have a significant economic impact on a substantial number of small entities. This rule will directly affect States.

In addition, Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of Section 604 of the RFA. For purposes of Section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. Therefore, the Secretary has determined and we certify that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2008 that threshold level is approximately \$130 million. Since this rule would not mandate spending on State, local, or tribal governments in the aggregate, or by the private sector of \$130 million or more in any 1 year, the requirements of the UMRA are not applicable.

Based upon the parameters of this rule and comments received, we do not believe the costs incurred by States will be significant. The final rule allows the DSH audits to be part of a hospital's annual financial audit (for example, the auditors would follow the DSH limit protocol provided in the regulation), which means a portion of the audit costs could actually be borne by the hospitals and not the States. Based upon comments received, it appears that most States want to incorporate the DSH audit into the annual hospital financial audits. If that is the case, the costs to the hospital should be minimal as well since the annual hospital financial audit is already a requirement.

It is further unknown if any States will contract with an independent accounting firm to conduct the audit. While there would be a contracting cost to the State, it is unknown what that cost would be and we believe it unlikely that States will avail themselves of this option. The final rule does allow for the use of the Single State Auditor to perform the DSH audit and if that is done, CMS would match the State audit costs at the 50 percent administrative matching rate.

Regardless of the mechanism for conducting the DSH audit, the auditor will be using existing documentation (for example, hospital cost reports, hospital accounting records, and MMIS) and apply the methodology provided by this rule, which should result in nominal costs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs of State and local governments, preempts State law, or otherwise has Federalism implications. Since this rule would not impose any costs on State or local governments, preempt State law, or otherwise have Federalism implications, the requirements of E.O. 13132 are not applicable.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

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42 CFR Part 447

Accounting, Administrative practice and procedure, Drugs, Grant programs--health, Health facilities, Health professions, Medicaid, Reporting and recordkeeping requirements, and Rural areas.

42 CFR Part 455

Fraud, Grant programs--health, Health facilities, Health professions, Investigations, Medicaid, and Reporting and recordkeeping requirements.

The Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as follows:

PART 447--PAYMENTS FOR SERVICES

1. The authority citation for part 447 continues to read as follows:

Authority: Sec 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 447.299 is amended by--

A. Redesignating existing paragraphs (c) and (d) as paragraphs (d) and (e).

B. Adding a new paragraph (c) to read as set forth below.

Sec. 447.299 Reporting requirements.

* * * * *

(c) Beginning with each State's Medicaid State plan rate year 2005, for each Medicaid State plan rate year, the State must submit to CMS, at the same time as it submits the completed audit required under Sec. 455.204, the following information for each DSH hospital to which the State made a DSH payment in order to permit verification of the appropriateness of such payments:

(1) Hospital name. The name of the hospital that received a DSH payment from the State, identifying facilities that are institutes for mental disease (IMDs) and facilities that are located out-of-state.

(2) Estimate of hospital-specific DSH limit. The State's estimate of eligible uncompensated care for the hospital receiving a DSH payment for the year under audit based on the State's methodology for determining such limit.

(3) Medicaid inpatient utilization rate. The hospital's Medicaid inpatient utilization rate, as defined in Section 1923(b)(2) of the Act, if the State does not use alternative qualification criteria described in paragraph (c)(5) of this section.

(4) Low income utilization rate. The hospital's low income utilization rate, as defined in Section 1923(b)(3) of the Act if the State does not use alternative qualification criteria described in paragraph (c)(5) of this section.

(5) State defined DSH qualification criteria. If the State uses an alternate broader DSH qualification methodology as authorized in Section 1923(b)(4) of the Act, the value of the statistic and the methodology used to determine that statistic.

(6) IP/OP Medicaid fee-for-service (FFS) basic rate payments. The total annual amount paid to the hospital under the State plan, including Medicaid FFS rate adjustments, but not including DSH payments or supplemental/enhanced Medicaid payments, for inpatient and outpatient services furnished to Medicaid eligible individuals.

(7) IP/OP Medicaid managed care organization payments. The total annual amount paid to the hospital by Medicaid managed care organizations for inpatient hospital and outpatient hospital services furnished to Medicaid eligible individuals.

(8) Supplemental/enhanced Medicaid IP/OP payments. Indicate the total annual amount of supplemental/enhanced Medicaid payments made to the hospital under the State plan. These amounts do not include DSH payments, regular Medicaid FFS rate payments, and Medicaid managed care organization payments.

(9) Total Medicaid IP/OP Payments. Provide the total sum of items identified in Sec. 447.299(c)(6), (7) and (8).

(10) Total Cost of Care for Medicaid IP/OP Services. The total annual costs incurred by each hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals.

(11) Total Medicaid Uncompensated Care. The total amount of uncompensated care attributable to Medicaid inpatient and outpatient services. The amount should be the result of subtracting the amount identified in Sec. 447.299(c)(9) from the amount identified in Sec. 447.299(c)(10). The uncompensated care costs of providing Medicaid physician services cannot be included in this amount.

(12) Uninsured IP/OP revenue. Total annual payments received by the hospital by or on behalf of individuals with no source of third party coverage for inpatient and outpatient hospital services they receive. This amount does not include payments made by a State or units of local government, for services furnished to indigent patients.

(13) Total Applicable Section 1011 Payments. Federal Section 1011 payments for uncompensated inpatient and outpatient hospital services provided to Section 1011 eligible aliens with no source of third party coverage for the inpatient and outpatient hospital services they receive.

(14) Total cost of IP/OP care for the uninsured. Indicate the total costs incurred for furnishing inpatient hospital and outpatient hospital services to individuals with no source of third party coverage for the hospital services they receive.

(15) Total uninsured IP/OP uncompensated care costs. Total annual amount of uncompensated IP/OP care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospital services they receive. The amount should be the result of subtracting paragraphs (c)(12) and (c)(13), from paragraph (c)(14) of this section. The uncompensated care costs of providing physician services to the uninsured cannot be included in this amount. The uninsured uncompensated amount also cannot include amounts associated with unpaid co-pays or deductibles for individuals with third party coverage for the inpatient and/or outpatient hospital services they receive or any other unreimbursed costs associated with inpatient and/or outpatient hospital services provided to individuals with those services in their third party coverage benefit package. Nor does uncompensated care costs include bad debt or payer discounts related to services furnished to individuals who have health insurance or other third party payer.

(16) Total annual uncompensated care costs. The total annual uncompensated care cost equals the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospital services they receive less the sum of regular Medicaid FFS rate payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, uninsured revenues, and Section 1011 payments for inpatient and outpatient hospital services. This should equal the sum of paragraphs (c)(11) and (c)(15) subtracted from the sum of paragraphs (c)(9), (c)(12) and (c)(13) of this Section.

(17) Disproportionate share hospital payments. Indicate total annual payment adjustments made to the hospital under Section 1923 of the Act.

(18) States must report DSH payments made to all hospitals under the authority of the approved Medicaid State plan. This includes both in-State and out-of-State hospitals. For out-of-State hospitals, States must report, at a minimum, the information identified in Sec. 447.299(c)(1) through (c)(6), (c)(8), (c)(9) and (c)(17).

* * * * *

PART 455--PROGRAM INTEGRITY: MEDICAID

1. The authority citation for part 455 continues to read as follows:

Authority: Sec 1102 of the Social Security Act (42 U.S.C. 1302).

2. Add new subpart D to read as follows:

Subpart D--Independent Certified Audit of State Disproportionate Share Hospital Payment Adjustments

Sec.

455.300 Purpose.

455.301 Definitions.

455.304 Condition for Federal financial participation (FFP).

Subpart D--Independent Certified Audit of State Disproportionate Share Hospital Payment Adjustments

Sec. 455.300 Purpose.

This subpart implements Section 1923(j)(2) of the Act.

Sec. 455.301 Definitions.

For the purposes of this subpart--

Independent certified audit means an audit that is conducted by an auditor that operates independently from the Medicaid agency or subject hospitals and is eligible to perform the DSH audit. Certification means that the independent auditor engaged by the State reviews the criteria of the Federal audit regulation and completes the verification, calculations and report under the professional rules

and generally accepted standards of audit practice. This certification would include a review of the State's audit protocol to ensure that the Federal regulation is satisfied, an opinion for each verification detailed in the regulation, and a determination of whether or not the State made DSH payments that exceeded any hospital's specific DSH limit in the Medicaid State plan rate year under audit. The certification should also identify any data issues or other caveats that the auditor identified as impacting the results of the audit.

Medicaid State Plan Rate Year means the 12-month period defined by a State's approved Medicaid State plan in which the State estimates eligible uncompensated care costs and determines corresponding disproportionate share hospital payments as well as all other Medicaid payment rates. The period usually corresponds with the State's fiscal year or the Federal fiscal year but can correspond to any 12-month period defined by the State as the Medicaid State plan rate year.

Sec. 455.304 Condition for Federal financial participation (FFP).

(a) General rule.

(1) The State must submit an independent certified audit to CMS for each completed Medicaid State plan rate year, consistent with the requirements in this subpart, to receive Federal payments under Section 1903(a)(1) of the Act based on State expenditures for disproportionate share hospital (DSH) payments for Medicaid State plan rate years subsequent to the date the audit is due, except as provided in paragraph (e) of this section.

(2) FFP is not available in expenditures for DSH payments that are found in the independent certified audit to exceed the hospital-specific eligible uncompensated care cost limit, except as provided in paragraph (e) of this section.

(b) Timing.

For Medicaid State plan rate years 2005 and 2006, a State must submit to CMS an independent certified audit report no later than the last day of calendar year 2009. Each subsequent audit beginning with Medicaid State plan rate year 2007 must be completed by the last day of the Federal fiscal year ending three years from the end of the Medicaid State plan rate year under audit. Completed audit reports must be submitted to CMS no later than 90 days after completion. Post-audit adjustments based on claims for the Medicaid State plan rate year paid subsequent to the audit date, if any, must be submitted in the quarter the claim was paid.

(c) Documentation.

In order to complete the independent certified audit, States must use the following data sources:

- (1) Approved Medicaid State plan for the Medicaid State plan rate year under audit.
- (2) Payment and utilization information from the State's Medicaid Management Information System.
- (3) The Medicare 2552-96 hospital cost report(s) applicable to the Medicaid State plan rate year under audit. If the Medicare 2552-96 is superseded by an alternate Medicare developed cost reporting tool during an audit year, that tool must be used for the Medicaid State plan rate year under audit.
- (4) Audited hospital financial statements and hospital accounting records.

(d) Specific requirements.

The independent certified audit report must verify the following:

(1) Verification 1: Each hospital that qualifies for a DSH payment in the State is allowed to retain that payment so that the payment is available to offset its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the Medicaid State plan rate year to Medicaid eligible individuals and individuals with no source of third party coverage for the services in order to reflect the total amount of claimed DSH expenditures.

(2) Verification 2: DSH payments made to each qualifying hospital comply with the hospital-specific DSH payment limit. For each audited Medicaid State plan rate year, the DSH payments made in that audited Medicaid State plan rate year must be measured against the actual uncompensated care cost in that same audited Medicaid State plan rate year.

(3) Verification 3: Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no third party coverage for the inpatient and outpatient hospital services they received as described in Section 1923(g)(1)(A) of the Act are eligible for inclusion in the calculation of the hospital-specific disproportionate share limit payment limit, as described in Section 1923(g)(1)(A) of the Act.

(4) Verification 4: For purposes of this hospital-specific limit calculation, any Medicaid payments (including regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments) made to a disproportionate share hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals,

which are in excess of the Medicaid incurred costs of such services, are applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third party coverage for such services.

(5) Verification 5: Any information and records of all of its inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments under this Section; and any payments made on behalf of the uninsured from payment adjustments under this Section has been separately documented and retained by the State.

(6) Verification 6: The information specified in paragraph (d)(5) of this Section includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g)(1) of the Act. Included in the description of the methodology, the audit report must specify how the State defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they received.

(e) Transition Provisions:

To ensure a period for developing and refining reporting and auditing techniques, findings of State reports and audits for Medicaid State Plan years 2005-2010 will not be given weight except to the extent that the findings draw into question the reasonableness of State uncompensated care cost estimates used for calculations of prospective DSH payments for Medicaid State plan year 2011 and thereafter.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: September 25, 2008.

Kerry Weems,
Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: October 29, 2008.

Michael O. Leavitt,
Secretary.

Attachment C
General DSH Audit and Reporting Protocol
CMS-2198-F 2

Areas of Responsibility
States:

1. States are responsible for obtaining the independent audit on an annual basis

In response to the statutory language, "independent," audits must be certified by Single State Audit Agency or any other CPA firm that operates independently from the Medicaid agency and the subject hospitals. States may not rely on non-CPA firms, fiscal intermediary, and independent certification programs currently in place to audit UCC, nor expand hospital financial statements to obtain audit certification of the hospital specific DSH limits.

The Single State Audit is an Office of Inspector General process. Although there may be some overlap in resources used to complete both audits, the DSH Audit is particular to Medicaid and is the sole responsibility of CMS to enforce and monitor and thus cannot be combined within the Single State Audit Act.

2. Providing the auditor and the DSH hospitals subject to audit with instructions on the data elements necessary to insure compliance

The DSH audit will rely on existing cost reporting tools and documents as primary sources for the data necessary to evaluate DSH payments against hospital specific DSH costs. Two of the primary source documents are the Medicare 2552-96 hospital cost report and audited hospital financial statements (and other auditable hospital accounting records). Rather than requiring that states or hospitals create new documents and potentially new financial standards, CMS will rely on the financial standards that apply to the use of these documents in their current form. Any hospital participating in the Medicare program already completes the Medicare 2552-96 cost report and is familiar with the accounting standards applicable to this document. Similarly, hospital financial statements are subject to certain financial reporting standards to produce the information that will be used in the DSH audit. Each of these documents will produce data used to develop cost and payment information for the DSH audit using the financial reporting standards applicable to each.

Developing audit protocol for use by DSH hospitals to determine costs. This protocol should include instructions identifying the relevant sections of the cost report that reflect costs eligible for inclusion in developing the hospital specific DSH limit and must replace any current DSH survey information utilized by states. This protocol should include identification of all relevant hospital cost reports and financial statements and other auditable hospital accounting records associated with the audited Medicaid State plan rate year. Situations in which a hospital's fiscal year does not coincide with the Medicaid State plan rate year, hospitals will need to provide the two (or more, if there are short-period, i.e., less than twelve-month, cost reports involved) overlapping cost reports and financial statements and other auditable hospital accounting records to properly reflect cost incurred during the full State Plan rate year.

3. Provide DSH hospitals and auditor with fee for service (FFS) Medicaid IP and OP hospital days and charges based on Medicaid Management Information System (MMIS) data for the cost reporting period(s) covering the Medicaid State plan rate year under audit.

4. Provide DSH hospitals and auditor with all information related to IP/OP hospital regular Medicaid rate payments (including all rate add-ons), all Medicaid supplemental and enhanced payments, and all DSH payments made to each DSH hospital for the cost reporting year(s) covering the State plan rate year.

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5. Provide auditor with methodologies utilized by the State to determine DSH eligible hospitals under the Medicaid State plan (LIUR, MIUR, Other) and payment methodologies used to generate DSH payments under the approved Medicaid State plan.

6. Provide auditor with hospital-generated IP/OP hospital cost report information; Medicaid managed care IP/OP hospital days, charges, and payment information; and uninsured IP/OP hospital days, charges, and payment information received from DSH hospitals.

7. Report the findings of the audit to CMS within 90 days of receiving audit. In recognition of timing issues related to initiating the audit process. States may concurrently complete the Medicaid State plan rate year 2005 and 2006 audit by September 30, 2009. The report associated with Medicaid State plan rate years 2005 and 2006 are due no later than December 31, 2009 to CMS.

8. Use audit findings for rate year 2005 – 2010 to prospectively adjust DSH payments beginning with Medicaid State plan rate year 2011.

9. Use audit findings for rate year 2011 to determine over/underpayments (final report available in 2014).

DSH Hospitals:

1. Use the Medicare 2552-96 hospital cost report to determine cost center specific routine per diems and ancillary ratios of cost to charges (RCC) based on Medicare Cost Principles (Medicare cost allocation process).

2. Utilize MMIS data provided by the state for Medicaid FFS IP/OP hospital ancillary charges and Medicaid FFS IP hospital routine days.

3. Utilize hospital financial statements and other auditable hospital accounting records as source for IP/OP hospital Medicaid managed care ancillary charges and routine days and IP/OP hospital uninsured ancillary charges and routine days (individuals with no source of third party coverage). These charges and days will be used with cost center specific RCCs and per diems, respectively, to allocate hospital costs to each relevant payer category described above.

4. Utilize revenue information from financial statements and other auditable hospital accounting records to identify payments made by or on behalf of patients with no source of third party coverage for IP/OP hospital services. Note that payments for IP/OP hospital services from state-only or local-only programs for the uninsured should not be included as revenues.

5. Utilize revenue information from financial statements and other auditable hospital accounting records to identify Medicaid payments not directly paid by the State in which the hospital is located, including all IP/OP Title XIX payments from other States (regular, supplemental and enhanced and DSH), all payments from Medicaid managed care organizations for IP/OP hospital services provided to Medicaid MCO enrollees, and all payments from other non-State sources for Medicaid IP/OP hospital services.

6. Provide state with hospital specific cost and revenue data, including backup documentation, so that independent auditor may utilize in developing audit report. Continue to provide state information already required to determine DSH qualifications (LIUR, MIUR, other).

Auditor:

1. Review State's methodology for estimating hospital's OBRA 1993 hospital-specific DSH limit and the State's DSH payment methodologies in the approved Medicaid State plan for the State plan rate year under audit.
2. Review state's DSH audit protocol to ensure consistency with IP/OP Medicaid reimbursable services in the approved Medicaid State plan. Review DSH audit protocol to ensure that only costs eligible for DSH payments are included in the development of the hospital specific DSH limit.
3. Compile hospital specific IP/OP cost report data and IP/OP revenue data to measure hospital specific DSH limit in auditable year. In determining this limit, the auditor must measure both components of the hospital specific DSH limit. To determine the existence of a Medicaid shortfall, Medicaid IP/OP hospital costs (including Medicaid managed care costs) must be measured against Medicaid IP/OP revenue received for such services in the audited State Plan rate year (including regular Medicaid rate payments, add-ons, supplemental and enhanced payments and Medicaid managed care revenues). Costs associated with patients with no source of third party coverage must be reduced by applicable revenues and added to any Medicaid shortfall to determine total eligible DSH costs.
4. Compile total DSH payments made in auditable year to each qualifying hospital (including DSH payments received by the hospitals from other States).
5. Compare hospital specific DSH costs limits against hospital specific total DSH payments in the audited Medicaid State plan rate year. Summarize findings identifying any overpayments/underpayments to particular hospitals.

Data Sources:

The following are to be considered the primary data sources utilized by states, hospitals and the independent auditors to complete the DSH audit and the accompanying report. In many instances, hospital financial and cost report periods will differ from the Medicaid State plan rate year. In these instances, hospitals should use multiple audited financial reports and hospital cost reports to fully cover the Medicaid State plan rate year under audit. The data should be directly allocated based on the months covered by the financial or cost reporting period that directly related to the Medicaid State plan period under audit. For instance, if a Medicaid State plan rate year runs from 7/1/04 to 6/30/05 but a DSH hospital receiving payments under the Medicaid State plan operates its financial and cost reporting based on a calendar year, the hospital would need to use financial and cost reports for calendar years 2004 and 2005. The hospital would allocate 50% of all costs and revenues in each financial and cost reporting period to determine costs and revenues associated with the Medicaid State plan rate year 2005.

1. MMIS Data

State MMIS generated IP hospital payments, ancillary charges and routine days for the cost reporting period(s) covering the Medicaid State plan rate year under audit for each DSH hospital.

State MMIS generated OP hospital payments and ancillary charges for the cost reporting period(s) covering the Medicaid State plan rate year under audit for each DSH hospital.

2. Approved Medicaid State Plan

LIUR, MIUR or other DSH hospital determination criteria and data used to determine eligibility for the Medicaid State plan rate year under audit.

Medicaid State Plan DSH payment methodologies for the Medicaid State plan rate year under audit.

State DSH payments to each DSH hospital for the Medicaid State plan rate year under audit.

State methodology for determining the hospital-specific DSH limit, the data used to determine such limit and the hospital-specific cost limit generated by methodology and data for the Medicaid State plan rate year under audit.

3. Medicare 2552-96 Hospital Cost Report

Medicare 2552-96 hospital cost report(s) for the Medicaid State plan rate year under audit (finalized when available, or as filed).

4. Audited Hospital Financial Statements and Other Auditable Hospital Accounting Records

Hospital revenues from Medicaid managed care organizations, Medicaid payments from other States (regular payments including add-ons, supplemental and enhanced payments, DSH payments), and Medicaid IP/OP hospital payments from all sources other than the State from hospital financial reports and records for the cost reporting period(s) covering the Medicaid State plan rate year under audit.

Hospital revenues from or on behalf of with no source of third party coverage for the hospital services provided.

Days and charges for IP/OP Medicaid hospital services for services provided to out of state Medicaid patients.

Days and charges for IP/OP hospital services provided to patients with no source of third party coverage for the hospital services provided.

Days and charges for IP/OP hospital services provided to Medicaid managed care patients.

General Cost Determination: Uncompensated Care Cost Determination

Hospitals must use the Medicare 2552-96 Hospital Cost Report(s) for the Medicaid State plan rate year to determine allowable IP/OP Medicaid service costs and costs of providing IP/OP hospital services to patients with no source of third party coverage for the hospital services provided.

The Medicare cost allocation process will be used to determine facility costs for inclusion in determining DSH eligible hospital costs. In order to provide complete financial information for the Medicaid State plan rate year under audit, hospitals must use two or more Medicare costs reports if the cost reporting period does not correspond with the Medicaid State plan rate year under audit. Once costs are allocated according to the Medicare cost allocation process, those costs should be allocated to the Medicaid State plan rate year on a pro-rata basis to develop 12 full months of costs.

1. Hospitals determine IP FFS Medicaid costs

Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a per diem is computed for each routine cost center, and a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total
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allowable costs from each routine cost center are apportioned to a specific program by applying that cost center's program days to the cost center's computed per diem, and total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital inpatient fee-for-service Medicaid costs are the days and charges pertaining to hospital inpatient services furnished to Medicaid fee-for-service individuals. The primary source of the program data is the MMIS. The program days and charges must pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to inpatient hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to services paid by Title XIX fee-for-service. As required by the 2552-96

cost report apportionment process, the program data must be reported by hospital cost centers. By applying program days defined above to the cost-report-computed per diems and applying program charges defined above to the cost report-computed cost-to-charge ratios, and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital inpatient fee-for-service Medicaid cost

2. Hospitals determine IP Medicaid managed care costs

Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a per diem is computed for each routine cost center, and a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each routine cost center are apportioned to a specific program by applying that cost center's program days to the cost center's computed per diem, and total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital inpatient Medicaid managed care costs are the days and charges pertaining to hospital inpatient services furnished to individuals under Medicaid managed care. The program data must be derived from auditable documentation and may include reports from Medicaid managed care plans. The auditable documentation must show that the program days and charges pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to inpatient hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to Title XIX services paid by the Medicaid managed care plans. As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.

By applying program days defined above to the cost-report-computed per diems and applying program charges defined above to the cost-report-computed cost-to-charge ratios, and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital inpatient Medicaid managed care cost.

3. Hospitals determine IP costs for hospital services provided to patients with no source of third party coverage

Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a per diem is computed for each routine cost center, and a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each routine cost center are apportioned to a specific program by applying that cost center's program days to the cost center's computed per diem, and total allowable

costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital uninsured inpatient costs are the days and charges pertaining to hospital inpatient services furnished to individuals who have no source of third party coverage. The program data must be derived from auditable documentation. The auditable documentation must show that the program days and charges pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to inpatient hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to services furnished to individuals who have no source of third party coverage (services furnished to individuals who are covered only by state-only/local governmental programs may be included). As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.

By applying the program days defined above to the cost-report-computed per diems and applying the program charges defined above to the cost-report-computed cost-to-charge ratios, and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital uninsured inpatient cost.

4. Hospitals determine OP FFS Medicaid costs

Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital outpatient fee-for-service Medicaid costs are the charges pertaining to hospital outpatient services furnished to Medicaid fee-for-service individuals. The primary source of the program data is the MMIS. The program charges must pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to outpatient hospital services furnished and not services furnished by practitioners which can be billed separately as professional services; and c) only to services paid by Title XIX fee-for-service. As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.

By applying the program charges defined above to the cost-report-computed cost-to-charge ratios and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital outpatient fee-for-service Medicaid cost.

5. Hospitals determine OP Medicaid managed care costs

Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital outpatient Medicaid managed care costs are the charges pertaining to hospital outpatient services furnished to individuals under Medicaid managed care. The program data must be derived from auditable documentation and may include reports from Medicaid managed care plans. The auditable documentation must show that the program charges pertain: a) only to services furnished by the

hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to OP hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to Title XIX services paid by the Medicaid managed care plans. As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.

By applying program charges defined above to the cost-report-computed cost-to-charge ratios and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital outpatient Medicaid managed care cost.

6. Hospitals determine OP costs for hospital services provided to patients with no source of third party coverage

Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital uninsured outpatient costs are the charges pertaining to hospital outpatient services furnished to individuals who have no source of third party coverage. The program data must be derived from auditable documentation. The auditable documentation must show that the program charges pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to OP hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to services furnished to individuals who have no source of third party coverage (services furnished to individuals who are covered only by state-only/local governmental programs may be included). As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.

By applying the program charges defined above to the cost-report-computed cost-to-charge ratios and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital uninsured outpatient cost.

7. Hospital report revenues from Medicaid managed care organizations, Medicaid payments from other States (regular payments including add-ons, supplemental and enhanced payments, DSH payments), and other non-State Medicaid payments

Since the State's MMIS system will not have information about payments generated from Medicaid managed care organizations or Medicaid and DSH payments from other States and other non-State sources, hospitals must use their financial statements and other auditable hospital accounting records to identify:

All Medicaid managed care payments received during the cost reporting period(s) covering the Medicaid State plan rate year under audit. Any managed care payments received that include payments for services other than those that qualify for IP or OP hospital services must be separated to include that portion of the payment applicable to IP or OP hospital services. If the hospital cannot separate the component parts of a managed care payment, the full amount of the payment must be counted as in IP/OP hospital managed care payment.

All Medicaid payments received from out of state during the cost reporting period(s) covering the Medicaid State Plan rate year under audit. Hospitals must separately identify a) Medicaid regular rate payments (including add-ons); b) supplemental Medicaid payments, and; c) DSH payments.

All Medicaid payments received during the cost reporting period(s) covering the Medicaid State plan rate year under audit from non-State sources not already accounted for, including payments from or on behalf of patients for Medicaid services.

8. Hospital report revenue from or on behalf of patients with no source of third party coverage for the hospital services provided

Since the State's MMIS system will not have information about payments by or on behalf of patients with no source of third party coverage for the hospital services provided, hospitals must use their financial statements and other auditable hospital accounting records to identify:

All payments received during cost reporting period(s) covering the Medicaid State plan rate year under audit by or on behalf of patients with no source of third party coverage. There will be no attempt to allocate payments received during the state plan rate year to services provided in prior periods. Since the goal of the audit is to determine uncompensated DSH costs in a given Medicaid State plan rate year, all payments received in the year will be counted as revenue to the hospital in that same year. It is understood that some costs incurred during the State Plan rate year under audit may be associated with future revenue streams (legal decisions, payment plans, and recoveries) but that the payments are not counted as revenue until actually received.

IP or OP hospital payments received from state or local government programs for individuals with no source of third party coverage for the hospital services they received should not be included as a revenue in this category.

9. Auditor applies MMIS generated total IP/OP hospital Medicaid FFS payments (other than DSH) to total IP/OP hospital Medicaid FFS cost

10. Auditor applies IP/OP hospital Medicaid managed care revenues against IP/OP hospital Medicaid managed care costs

11. Auditor applies IP/OP hospital revenues for patients with no source of third party coverage against the costs for IP/OP hospital services provided to such individuals

12. Sum of steps 9-11 are summed to determine the total amount of costs eligible for DSH reimbursement and considered the OBRA 1993 hospital specific DSH limit

13. Compare DSH payments to the amount determined in step 12

Attachment D

Additional Information on the DSH Reporting and Audit Requirements

Best Available Information/Cost Report Procedures

1. How can an independent auditor certify that DSH payments do not exceed the hospital-specific DSH limits if data used for calculating the limits is derived, at least in part, from as-filed Medicare cost reports?

Certification means that the independent auditor engaged by the State follows the criteria of the Federal audit regulation and completes the verification, calculations and report under the professional rules and generally accepted standards of audit practice. This certification would include an assessment of the State's audit protocol to ensure that the Federal regulation is satisfied, an opinion for each verification detailed in the regulation, and a determination of whether or not the State made DSH payments that exceeded any hospital-specific DSH limit in the Medicaid State plan rate year under audit. The certification should also identify any data issues or other caveats that the auditor identified as impacting the results of the audit.

We expect that reports and audits will be based on the best available information. If audited Medicare cost reports are not available within the timeframe allowed for the reporting and audit submission, the DSH report and audit may need to be based on Medicare cost reports as filed. However, in the final rule, CMS modified the timeline for report and audit submission to allow States additional time for the inclusion of the most accurate and complete data possible. The required reports and audits may be submitted as late as the last day of the Federal fiscal year ending three years after the end of the Medicaid State plan rate year, with a special timing provision for the audits for 2005 and 2006, which will be due by December 31, 2009. Additionally, CMS has developed a General DSH Audit and Reporting Protocol that should assist States and auditors in utilizing information from each data source and developing methods to determine uncompensated costs of furnishing hospital services to the Medicaid and uninsured populations. The protocol is available on the CMS website at www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2198FRptProtocol.pdf.

It should be noted that in light of States' concerns regarding budget cycles, planning complications, and the economic downturn, CMS has determined that it will apply a flexible enforcement strategy designed to ensure that States have sufficient time to properly implement the new requirements without undue hardship. Thus, CMS will not find a State to be out of compliance with the DSH reporting and auditing requirements for the initial (2005 and 2006) Medicaid State plan rate years until December 31, 2010. Pursuant to the provisions of the regulation, independent audits must begin with Medicaid State plan year 2005 and must be completed no later than September 30, 2009, for the State plan rate years 2005 and 2006. Audits and reports for State plan rate years 2005 and 2006 are due to CMS on or before December 31, 2009.

2. If as-filed Medicare cost reports are used to calculate hospital-specific DSH limits, do limits have to be adjusted to reflect the final settlement of the cost report or the outcome of cost report appeals?

We expect that reports and audits will be based on the best available information. If audited Medicare cost reports are not available, the DSH report and audit may need to be based on Medicare cost reports as filed. Most hospital cost reports are finalized within two years of the period being audited but there is always the possibility of post-audit adjustments. To the extent that such adjustments to cost reports affects Medicaid payments, States should notify CMS of the adjustments to the cost reports and any subsequent DSH audit report changes as well as make appropriate prior period adjustments through the MBES/CBES system. Additionally, we would anticipate the auditor's certification would identify any data issues or other caveats that the auditor has identified as impacting the results of the audit.

The statutory authority instructed States to report and audit specific payments and specific costs. Consistent with that provision, States must perform audits associated with defined periods of time and must identify the actual costs incurred and payments received during that defined time period. In order for the audits to

properly measure these elements and in consideration of the many comments related to retroactivity and timing issues associated with gathering the data necessary to identify the costs and revenues, CMS has made several revisions to the final rule including identifying that: (i) the Medicaid State plan rate year 2005 is the first time period subject to the audit; and, (ii) the deadline on reporting the audit findings has been extended to at least three full years after the close of the Medicaid State plan rate year subject to audit.

The required reports and audits may be submitted as late as the last day of the Federal fiscal year ending three years after the end of the Medicaid State plan rate year, with a special timing provision for the audits for 2005 and 2006, which will be due by December 31, 2009. This three year period accommodates the one-year concern expressed in many comments regarding claims lags and is consistent with the varying cost report period and adjustments.

3. Data derived from multiple cost report years might have to be used in fulfilling audit and reporting requirements for a given State plan rate year. In order to complete reporting and auditing requirements relating to State plan rate years 2005 and 2006, for the 2005 and 2006 reports, would it be acceptable to obtain 2004 and 2007 costs from submitted or unreviewed cost reports?

In instances where the hospital financial and cost reporting periods differ from the Medicaid State plan rate year, States and auditors may need to evaluate multiple audited hospital financial reports and cost reports to fully cover the Medicaid State plan rate year under audit. Typically, at most, two financial and/or cost reports should provide the appropriate data. Please note that there are some circumstances where more than two cost reports are needed to cover a State plan year. Some occasions call for a hospital to file short-period cost reports within a normal 12-month cost reporting period. For example, if there is a change of ownership in the middle of a fiscal period, the hospital will have to file more than one cost report during its 12-month fiscal period. The data may need to be allocated based on the months covered by the financial or cost reporting period that are included in the Medicaid State plan period under audit. CMS has developed a General DSH Audit and Reporting Protocol to assist States in using the information from each source identified above and developing the methods under which costs and revenues will be determined. The protocol is available on the CMS website at www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2198FRptProtocol.pdf.

We expect that all reports and audits will be based on the best available information. If audited Medicare cost reports are not available, the DSH report and audit may need to be based on Medicare cost reports as filed. Moreover, in order to ensure a period for developing and refining audit practices, we are providing for a transition period through Medicaid State plan rate year 2010, before audit results will be given weight other than in making prospective estimates of hospital costs for the purposes of ongoing DSH payments.

4. Can independent auditors utilize a risk-based approach to auditing hospitals or utilize some materiality guideline in developing different levels of data analysis for different hospitals? Additionally, does CMS expect that all hospitals are audited by the independent auditor annually?

The DSH audit and report is a necessary part of the administration of the Medicaid program. The purpose of the audit is to ensure that States make DSH payments under their Medicaid program that are in compliance with section 1923 of the Act. The audit does not encompass the review of the State's overall Medicaid program; it simply ensures that one portion of the program is conducted in line with Federal statutory limits. In addition, the DSH audit will rely on financial and cost report data provided by hospitals that are subject to generally accepted accounting principles as part of their primary reporting function.

There is no statutory authorization for an exception to audit and reporting requirements with respect to hospitals that receive DSH payments. The audit and reporting requirements under section 1923(j) of the Act apply to all States that make DSH payments, with respect to each hospital receiving a DSH payment. The statute further requires that CMS obtain information sufficient to verify that such payments are appropriate. Relying on a sample of cost reports and financial information will not ensure that each DSH payment is appropriate and does not exceed the hospital-specific DSH limit.

The data elements necessary for the State to complete the DSH audit and report should, in part, be information the State already gathers to administer the DSH program. The responsibility of the auditor is to measure DSH payments received by a hospital in a particular year against the eligible uncompensated care costs of that hospital in that same year as determined using the data provided in the cost, utilization and financial reporting documents described in the preamble to the final rule. Additionally, auditing a State's overall DSH payment methodology will not ensure that DSH payments to each hospital do not exceed the statutorily required hospital-specific DSH limit.

Finally, in order to certify to the verifications, the auditors should follow generally accepted auditing practices and requirements to assure a thorough and complete audit has been conducted. The auditor must develop sufficient confidence in the data to certify the results for the State plan rate year subject to the audit. The final rule does not eliminate any flexibility that independent auditors might have in using accepted professional methodologies to conduct the audit and to certify to the verifications. However, the independent certified audits required to be submitted must be performed in compliance with section 1923(j) and implementing regulations as a condition for receiving Federal payments under section 1903(a)(1) and 1923 of the Act.

5. If DSH payments are based on hospital-specific DSH limits from prior year audits, recoupments and DSH payment redistribution might be necessary on an annual basis. How does CMS expect States to deal with this cost and with the potential hardship to the hospitals?

This regulation does not require States to implement retrospective DSH payment methodologies or otherwise change the basic approach to DSH payment used by the States. Nor does it require delay in making DSH payments consistent with the authority of the approved Medicaid State plan. CMS recognizes that States may need to estimate uncompensated care to determine DSH payments in an upcoming Medicaid State plan rate year, indeed, this is currently the way most States distribute DSH payments. The regulation is intended to ensure that those estimates do not exceed the actual hospital-specific limit in the year in which the payments are received.

States retain considerable flexibility in setting DSH State plan payment methodologies to the extent that such methodologies are consistent with 1923(c) and all other applicable statute and regulations. This regulation provided for time frames that should provide States with accurate information with which to determine prospective DSH payments and time to review and adjust rates once actual eligible uncompensated care amounts are determined. States will have to determine how to best ensure that prospective DSH methodologies do not result in payments that exceed hospital-specific DSH limits, either by revising those methodologies or by providing for reconciliation of prospective payments with those limits. Because FFP is only available for DSH payments that do not exceed the hospital-specific limit, some States may determine that a retrospective DSH payment methodology or a DSH reconciliation is a reasonable way to manage its DSH allotment.

CMS as always is available to offer technical assistance to States in developing such methodologies. Additionally, CMS included a transition period in the regulation to ensure that States may adjust prospective estimates to avoid any immediate adverse fiscal impact.

- 6. The final regulation requires a determination of whether or not the State made DSH payments that exceeded the hospital-specific DSH limit for any hospital in the Medicaid State plan rate year under audit. If the DSH audit identifies DSH payments made to a hospital in excess of the hospital-specific DSH limit, how should States treat such payments if the hospitals are no longer eligible for DSH, are bankrupt, or no longer exist?**

As stated in the final rule, beginning in Medicaid State plan rate year 2011, to the extent that audit findings demonstrate that DSH payments made in that year exceed the documented hospital-specific cost limits, CMS will regard them as representing discovery of overpayments to providers that, pursuant to 42 CFR Part 433, Subpart F, triggers the return of the Federal share to the Federal government (unless the DSH payments are redistributed by the State to other qualifying hospitals as an integral part of the audit process). This is not a “penalty” but instead reflects adjustment of an overpayment that was not consistent with Federal statutory limits. However, we note that, to the extent that States wish to redistribute any DSH payments that exceeded a particular hospital-specific limit, the Federally approved Medicaid State plan must reflect that payment policy and allow for individual payment adjustments based on the audit. Further, States need not refund the Federal share of overpayments made to providers who are determined to be bankrupt or out of business in accordance with 42 CFR 433.318.

- 7. To meet the reporting and auditing requirement, States must perform audits associated with defined periods of time and must identify the actual costs incurred and payments received during that defined time period. Can a State use adjudicated claims date, or must they change to admission or discharge date, which is reflected in the comment and response of the DSH final rule?**

Section 1923(g) of the Social Security Act imposes a limit that is based in part on a year’s worth of services. The preamble language is merely illustrative of two approaches some States may already use to determine the volume of Medicaid services and payments to be included in the yearly limit and was not intend to be all inclusive. Adjudicated claims date would be another acceptable approach to determine the amount of services furnished during the year. However, the approach used must be consistent with the approved State plan language for the specified time period and should be clearly defined in the audit report.

- 8. What does the final rule mean by the term Medicaid State plan rate year?**

In using the term State plan rate year, we recognize that while many States may set rates on a State fiscal year basis, some States set rates on a calendar or other annual basis and establish DSH limits accordingly. The State plan rate year is therefore the 12-month period defined by a State’s approved State plan in which the State estimates eligible uncompensated care costs and determines corresponding DSH payments as well as other Medicaid payment rates.

- 9. Some States utilize certified public expenditures (CPE) to finance the non-Federal share of DSH payments made up to hospital-specific DSH limits. Should States modify existing State plan provisions and/or special terms and conditions (STC) of section 1115 demonstrations in instances where the approved State plan and/or STCs methods for calculating costs for these CPE-funded payments differ from the method for calculating the hospital-specific limit required by the final regulation and associated DSH General Auditing and Reporting Protocol?**

To ensure that claims for DSH expenditures do not exceed hospital-specific DSH limits, States should modify their methods for calculating CPE-funded DSH payments to the extent that the approved State plan and/or STCs methods vary from that required by the final DSH audit regulation and associated DSH General Auditing and Reporting Protocol. If this requires a modification to the State plan or 1115 STCs, State should submit a State plan amendment or section 1115 demonstration amendment, respectively.

The final regulation does include a transition period to ensure that States may adjust uncompensated care estimates prospectively to avoid any immediate adverse fiscal impact and to assist States in ensuring that future DSH payments do not exceed the hospital-specific DSH limit. Additionally, to permit States an opportunity to develop and refine audit procedures, audit findings from Medicaid State plan rate year 2005-2010 will be limited to use for the purpose of estimating prospective hospital-specific uncompensated care cost limits in order to make actual DSH payments in the upcoming Medicaid State plan rate years. CMS is not requiring retroactive collection for Medicaid State plan rate years that have already passed. By using that time to improve State DSH payment methodologies, States may avoid circumstances in which DSH payments that exceed Federal statutory limits must be recouped from hospitals.

Audit Reports

10. Please provide clarification on the extent to which the State may rely upon hospitals to perform the DSH audit. Please clarify whether the State may rely upon hospitals' current or expanded financial audits for the certification of the hospital-specific DSH limits.

As stated in the final rule, the responsibility for certification of an independent audit rests with the State. States must engage an independent auditor to certify that the requirements of the Federal regulation are satisfied, to provide an opinion for each specified verification, and to make a determination as to whether any DSH payments exceeded any hospital's specific DSH limit. States would not meet the independent audit certification requirement by merely expanding audits of hospital financial statements to obtain audit certification from each hospital. However, States may utilize an independent auditor to independently analyze and certify information submitted by each hospital to the State.

Furthermore, the mere fact that a specific auditing entity completes a Medicaid financial audit for a hospital does not necessarily preclude the State from contracting with that auditing entity to complete the independent DSH audit. To the extent that the auditor attests in the DSH audit report that they meet the requirements for auditor independence described in Chapter 3 of the General Accounting Organizations General Audit Standards (GAGAS), an auditing entity of any hospital's financial audit may be eligible to complete the certified DSH audit for the State.

11. Please provide guidance on what auditing standards and procedures should be used in undertaking the DSH audit as well as what type of report auditors should issue.

The purpose of the DSH audit is to ensure that Medicaid DSH payments comply with Federal statutory limits. The DSH audit will necessarily rely upon financial and cost report data that are subject to generally accepted accounting principles, and accounting principles specific to hospital accounting under federal grant programs.

Audit procedures that are in accordance with applicable industry standards would meet the criteria established within the final rule if the auditors certify the audit in accordance with the definition of "independent certified audit" as defined at 455.301 of the final rule. We understand that the term "certification" may have specific meaning within the auditing profession. Our use of the term "certification" for purposes of DSH audits is limited to the actions set forth at 455.301. For this purpose, certification means that the auditor attests to qualifying as an independent auditor, has reviewed the criteria of the Federal

audit regulation and has completed the verification, calculations, and report under professional rules and generally accepted standards of audit practice. To the extent that the auditor decides that specific methods (which may include requirements beyond the scope of those specifically outlined within the regulation and protocol) are necessary to certify to the audit in accordance with the certification criteria at 455.301 and 455.304, then the auditor should employ these methods. As noted in 455.301, the certification should identify any data issues or other caveats that the auditor identifies as impacting the results of the audit.

We look forward to working with States in refining the auditing process throughout the transition period. Once States and CMS gain greater experience with the auditing process, CMS will work further with States to highlight best practices and auditing methods.

12. The 2005 and 2006 DSH audit reports are to be completed by September 30, 2009, and must be submitted to CMS by December 31, 2009. Are States able to grant extensions to auditors to complete the audits subsequent to September 30, if the final report is still delivered to CMS by December 31, 2009?

CMS has determined that it will apply a flexible enforcement strategy designed to ensure that States have sufficient time to properly implement the new requirements without undue hardship. Thus, CMS will not find a State to be out of compliance with the DSH reporting and auditing requirements for the initial (2005 and 2006) Medicaid State plan rate years until December 31, 2010. We do not anticipate any further delay of compliance enforcement, or any delay of compliance enforcement for subsequent audit years.

Even though CMS will be delaying compliance enforcement, CMS expects that States will be making good faith efforts to comply with the new requirements. We asked each State to identify, and to provide in writing to its respective CMS Associate Regional Administrator, a contact individual by September 30, 2009 to brief CMS representatives on the State's compliance status and progress. Based on those discussions, some States were/may be asked for detailed information about compliance efforts.

The final rule included a transition period recognizing that auditing processes and techniques may need to be refined. This transition period lasts through Medicaid State plan rate year 2010, before audit results will be given weight other than in making prospective estimates of hospital costs for the purposes of ongoing DSH payments. In the transition, CMS will work with States that make a good faith effort to fulfill all of the DSH reporting and auditing requirements and that also submit a final report to CMS by the December 31 deadline. It should be noted that States will still be expected to make DSH payments that conform to the hospital-specific limits beginning in 2011.

13. The rule states that the 2005 and 2006 DSH audit reports are to be submitted to CMS by December 31, 2009. What method will CMS use to determine submission date?

CMS has determined that it will apply a flexible enforcement strategy designed to ensure that States have sufficient time to properly implement the new requirements without undue hardship. CMS will not find a State to be out of compliance with the DSH reporting and auditing requirements for the initial (2005 and 2006) Medicaid State plan rate years until December 31, 2010. We do not anticipate any further delay of compliance enforcement, or any delay of compliance enforcement for subsequent audit years. We asked each State to identify, and to provide in writing to its respective CMS Associate Regional Administrator, a contact individual by September 30, 2009 to brief CMS representatives on the State's compliance status and progress. Based on those discussions, some States were/may be asked for detailed information about compliance efforts.

When States have completed the DSH audits and reports, they should submit the required reports and audits electronically via email to the Associate Regional Administrator of their respective CMS Regional Office on or before the applicable deadline. States are encouraged to carbon copy their Regional Office National Institutional Reimbursement Team (NIRT) representative and CMS Regional Office State representative as well. The receipt date will be the email creation and submission date as indicated on the email.

Certified audits should be submitted in a PDF format using an Adobe Acrobat application and should contain a PDF file of the completed reporting element template. All audit files should be submitted in zip data compression formats to ensure ease of electronic delivery.

CMS is exploring the possibility of including the required reporting elements into the MBES process and will provide additional guidance in the near future. Absent the MBES reporting process, States should submit the report as an excel spreadsheet in addition to the PDF format included in the certified audit report.

14. Is CMS planning on setting a DSH payment threshold below which some or all of the reporting requirements will be waived?

There is no statutory authorization for an exception to audit and reporting requirements with respect to hospitals that receive DSH payments. The audit and reporting requirements under section 1923(j) of the Act apply to all States that make DSH payments, with respect to each hospital receiving a DSH payment. As we noted in the preamble to the final rule, the statute requires that each State report to CMS data, and submit a certified audit, that verifies that all hospitals receiving DSH payments under the Medicaid State plan actually qualify to receive such payments and that such payments do not exceed the hospital-specific DSH limit. Even if a State only makes DSH payments under its approved Medicaid State plan that relate to the uncompensated care of providing inpatient and outpatient hospital services to Medicaid individuals (that is, Medicaid shortfall), it would be possible for payments to a hospital to exceed the hospital-specific limit if the hospital had a surplus in furnishing hospital services to the uninsured. While this may be an unlikely circumstance, we cannot at this time be certain that it never occurs. Therefore, in such a circumstance we will accept reporting limited to Medicaid uncompensated care only when the hospital provides a certification that it incurred additional uncompensated care costs serving uninsured individuals. When we review certified audit reports submitted by States, we will consider whether more flexibility would be warranted, and we may address the issue in future reporting instructions. However, prior to receiving the first set of annual State reports, CMS is not contemplating any changes to the reporting requirements.

Auditor Independence

15. What constitutes an independent auditor?

Medicaid regulations at 42 CFR 455.301 define a certified independent audit in part to mean an audit that is conducted by an auditor that operates independently from the Medicaid agency or subject hospital. The intent is for the auditor to be fully able to render objective and impartial judgment on all matters relating to a required DSH audit. Examples of potential conflicts for audit entities would be: calculating a State's DSH payments under the Medicaid State plan; developing State plan DSH payment methodologies for States; preparing uninsured/Medicaid source documents and/or originating data relating to the DSH program on behalf of subject hospitals and/or the State; serving as auditor to any subject hospital or the State agency; and possessing a direct or indirect financial interest in the State's DSH program. In this context, independence generally means that the audit organization and individual auditor is free of any impairment that may in fact or in appearance preclude an impartial opinion or reporting.

States are responsible for ensuring that no possible impairment exists between the auditing organization/auditors and the Medicaid agency and/or hospital. Within the auditing profession, standards have developed to help guide auditors and/or their clients with respect to independence and impairments that might potentially compromise it. The final rule provides that these principles are to be applied to Medicaid DSH audits. The General Accountability Office (GAO), in Chapter 3 of its most recent revision to Government Auditing Standard, identifies specific criteria for independence and outlines impairments to independence in government auditing practices (<http://www.gao.gov/govaud/govaudhtml/index.html>).

While we believe these generally accepted standards relating to independence in government auditing to be well understood by the auditing profession and would expect their correct application to the required audits, there are some situations that may warrant additional review. For instance, section 3.29 of the General Standards outlines non-audit services that impair auditor independence. The section states certain non-audit services directly support an entity's operations and impair an audit organization's ability to meet overarching audit principles (in this case we would consider the "entity" to be the Medicaid agency and/or hospital). Some examples of these types of services that may impair independence for purposes of conducting the DSH audit include:

- a.* maintaining or preparing the audited entity's basic accounting records or maintaining or taking responsibility for basic financial or other records that the audit organization will audit;
- b.* posting transactions (whether coded or not coded) to the entity's financial records or to other records that subsequently provide input to the entity's financial records;
- c.* determining account balances or determining capitalization criteria;
- d.* designing, developing, installing, or operating the entity's accounting system or other information systems that are material or significant to the subject matter of the audit;
- e.* providing payroll services that (1) are material to the subject matter of the audit or the audit objectives, and/or (2) involve making management decisions;
- f.* providing appraisal or valuation services that exceed the scope described in paragraph 3.28 c;
- g.* recommending a single individual for a specific position that is key to the entity or program under audit, otherwise ranking or influencing management's selection of the candidate, or conducting an executive search or a recruiting program for the audited entity;
- h.* developing an entity's performance measurement system when that system is material or significant to the subject matter of the audit;
- i.* developing an entity's policies, procedures, and internal controls;
- j.* performing management's assessment of internal controls when those controls are significant to the subject matter of the audit;
- k.* providing services that are intended to be used as management's primary basis for making decisions that are significant to the subject matter under audit;
- l.* carrying out internal audit functions, when performed by external auditors; and
- m.* serving as voting members of an entity's management committee or board of directors, making policy decisions that affect future direction and operation of an entity's programs, supervising entity employees, developing programmatic policy, authorizing an entity's transactions, or maintaining custody of an entity's assets.

Further examples of such potential conflicts for audit entities would be: providing audit services for the Medicaid program generally (not specifically related to DSH payments) such as auditing cost reports or determining Medicaid service rates; serving as auditor to any subject hospital or the State agency; and possessing a direct or indirect financial interest in the State's Medicaid program.

There are situations in which sufficient firewalls exist between such services that would serve to eliminate the potential conflict regarding auditor independence. In such cases, States must explain why such an audit firm meets the GAGAS independence standards despite the appearance that the auditing entity is not independent. The audit firm must also declare its independence in the audit and report submitted to CMS.

States should look to the General Auditing Standards in their entirety to ensure that no possible impairments to independence exist.

For State plan rate year 2007 and thereafter, auditing organizations/auditors must submit a signed statement declaring independence of the respective Medicaid agency and hospitals. This statement should be included with the audit and report submitted to CMS on an annual basis.

16. Can States use provider-related donations, assessments, taxes on, or other similar funding arrangements with DSH hospitals to fund the required audits?

The DSH audit requirements and final rule do not supersede any Medicaid provisions relating to donations and taxes. As a practical matter, we do not see how a State could rely on “voluntary” donations to fund required Medicaid programs and expenses. As indicated in the preamble, section 1923(j) makes these DSH audit and reports a Medicaid program requirement and as such States are responsible for funding the costs to fulfill them just as they are any other Medicaid administrative costs. To the extent a State’s payment methodology for the audits and reports would be prohibited as an impermissible tax or donation, a State may not employ that methodology for purposes of funding the audits. States may not impose DSH fees or require financial participation in the funding of the audit as a condition for receiving DSH payments. Furthermore, to the extent that a provider-related donation presumed to be bona fide contains a hold harmless provision, it would not be considered a bona fide donation.

Revenue Recognition

17. How should States, hospitals, and auditors treat Medicaid payments received after the completion of the audit for a particular Medicaid State plan rate year?

In recognition of potential delays in obtaining needed information, we have extended the period for ongoing report and audit submission until the end of the Federal fiscal year that is at least three years after the close of the Medicaid State plan rate year. We believe that hospitals would have received most Medicaid, DSH payments, and other payments associated with that Medicaid State plan rate year.

Based on the modifications to the audit and reporting deadlines, the existing requirement at 42 CFR 447.45(d) for provider claims to be filed within a year from the date of service and promptly paid by the State, and the existing two-year timely claim filing requirement at 45 CFR 95.7, there should not be a significant adjustment to Medicaid payments that would warrant a corrected audit and report. To the extent that a significant adjustment to Medicaid payments occurs and States claim Federal matching dollars (or return Federal matching dollars) as a prior period adjustment, States should correct the audit and report by indicating post-audit adjustments to Medicaid and DSH payments (or uncompensated care costs if Medicaid payment adjustments affect the Medicaid shortfall). When post-audit retroactive adjustments to Medicaid payments are not significant, the payments should be measured during the audit of the Medicaid State plan rate year in which the revenues are received.

18. The final regulation and the preamble address which State plan rate year revenues apply to for purposes of calculating a hospital-specific DSH limits. It appears, however, that the preamble requires Medicaid payment offsets occurring after the completion of the DSH audit be applied duplicately in calculating hospital-specific DSH limits for two distinct State plan rate years. Can you confirm that these Medicaid revenues should be applied in calculating hospital-specific DSH limits for only one Medicaid State plan rate year?

Medicaid revenues identified in the post-audit period must only be applied against one State plan rate year for purposes of calculating hospital-specific DSH limits.

19. Against which Medicaid State plan rate year are revenues received by a hospital by or on behalf of either ‘self-pay’ or uninsured individuals during the Medicaid State plan rate year under audit offset?

The General DSH Audit and Reporting Protocol provides clarification regarding all payments received during cost reporting period(s) covering the Medicaid State plan rate year under audit by or on behalf of patients with no source of third party coverage. There will be no attempt to allocate payments received during the State plan rate year to services provided in prior periods. Since the goal of the audit is to determine uncompensated DSH costs in a given Medicaid State plan rate year, all payments received in the year will be counted as revenue to the hospital in that same year. It is understood that some costs incurred during the State Plan rate year under audit may be associated with future revenue streams (legal decisions, payment plans, and recoveries) but that the payments are not counted as revenue until actually received.

Allowable Costs/Medical Necessity

20. Will CMS be issuing guidance on what constitutes medically necessary services?

CMS does not intend to issue guidance on what constitutes medically necessary services. CMS will continue to allow States flexibility in determining medical necessity under their individual Medicaid programs within the guidelines of the Social Security Act provided at 1902(a)(30) and 1902(a)(19), and the implementing regulations at 42 CFR 440.230(d), which state "The [Medicaid] agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures." Generally, services that are considered reimbursable under the Medicaid State plan would also be considered as necessary services when calculating a hospital's eligible uncompensated care cost.

21. Are States required to follow only Medicare reasonable cost principles, or will they be allowed to establish allowable cost rules that may differ from Medicare?

As noted in the preamble to the final rule, section 1923(g)(1) of the Act provides for a Federal limitation based on costs that must be calculated in accordance with Federal accounting standards. The same methods used in preparing the Medicare 2552-96 cost report should be applied in determining costs to be used in calculating the hospital-specific DSH limits.

Hospitals' Medicare cost reports, audited financial statements, and accounting records should contain the information necessary for reporting and auditing responsibilities, in combination with information provided by the States' Medicaid Management Information Systems (MMIS) and the approved Medicaid State plan governing the Medicaid payments made during the audit period. The CMS developed General DSH Audit and Reporting Protocol will assist States and auditors in using information from each of these sources to determine allowable uncompensated care costs consistent with the statutory requirements. The protocol is available on the CMS Web site at:

www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2198FRptProtocol.pdf

22. If a State allows for graduate medical education as an allowable component of cost and is included in the Medicaid State Plan, should the State require the filing of Medicaid cost reports that incorporate the graduation medical education in the determination of program cost?

All costs that are associated with services that are defined and reimbursed under the approved Medicaid State plan as inpatient hospital services and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage may be included in calculating the hospital-specific DSH limit. To properly capture these costs in the hospital-specific DSH limit, State's should include these costs as part of the Medicare 2552-96 cost report step-down process and utilize the General DSH Audit and Reporting Protocol.

To the extent that a State allows graduate medical education (GME) as a component of cost and it is reimbursed under the Medicaid State plan, the State can include these costs in determining hospital-specific DSH limits. Please be reminded that the State still must use the cost reporting and apportionment process as prescribed by the Medicare 2552-96 identified in the General DSH Audit and Reporting Protocol.

23. "How should States treat unpaid Medicaid days or charges for purposes of calculating hospital-specific DSH limits?" What if the unpaid days are a result of untimely filing or a hospitals failure to seek prior authorization?

The hospital-specific DSH limit includes the costs incurred during the year of furnishing hospital services to Medicaid beneficiaries and the uninsured, net of Medicaid payments and payments made by or on behalf of the uninsured. To be included as Medicaid cost in the limit, a hospital service must be included in a State's definition of an inpatient hospital service or outpatient hospital service under the approved State plan and furnished to Medicaid eligible individuals.

Individuals with Medicaid or other third party coverage are not considered as uninsured under 1923(g)(1). Improper billing by a provider does not change the status of an individual as insured or otherwise covered. In no instance should costs associated with claims denied by a health insurance carrier for such a reason be included in the calculation of hospital-specific uncompensated care costs.

24. A Medicaid program in a State covers speech therapy services for beneficiaries under 18 years of age. A hospital in that State provided speech therapy to a Medicaid enrollee who was over 18 and claimed the services as uninsured care. Are the costs incurred by the hospital in providing the speech therapy service allowed to be included in the calculation of hospital-specific DSH limits?

In this example the costs associated with speech therapy services can be included in the calculation of hospital-specific DSH limits to the extent that such services are treated as "hospital services" under the State plan because the patient is eligible for Medicaid. The hospital-specific limit is based on the costs incurred for furnishing "hospital services" and does not include costs incurred for services that are outside either the State or Federal definition of inpatient or outpatient hospital services. While States have some flexibility to define the scope of "hospital services," States must use consistent definitions of "hospital services." Hospitals may engage in any number of activities, or may furnish practitioner or other services to patients, that are not within the scope of "hospital services," including speech therapy. A State cannot include in calculating the hospital-specific DSH limit cost of services that are not defined under its Medicaid State plan as a Medicaid inpatient or outpatient hospital service.

Determination of Uninsured Status

- 25. CMS seems to contradict itself in replying to the question of including patients who lack coverage for the service provided but not necessarily any coverage at all. CMS states that they have never read the statute to be service-specific and believe that such an interpretation would be inconsistent with the broad statutory references to insurance or other coverage. Furthermore, CMS replies that such a reading would result in cost shifting from private sector coverage to the Medicaid program. However, in a January 10, 1995 letter to Donna Checkett, Chair of the State Medicaid Director's Association, CMS clarified that: "it would be permissible for States to include in their determination of uninsured patients those individuals who do not possess health insurance which would apply to the service which the individual sought". Is it CMS's position now that it depends on whether the individual has creditable coverage consistent with 45 CFR 144 and 146 and not whether the specific service is covered?**

Section 1923(g)(1) of the Act refers to the costs of hospital services furnished by the hospital to individuals who have no health insurance (or other source of third party coverage). This language is not service-specific and any interpretation to the contrary would be inconsistent with the broad statutory references to insurance or other coverage. In an effort to adhere to a more accurate representation of the broad statutory references to insurance or other coverage; and to delineate more definitively the meaning of the term uninsured, CMS clarified the populations for which hospitals may calculate uncompensated care costs. We interpret the phrase "who have health insurance (or other third party coverage)" to broadly refer to individuals who have creditable coverage consistent with the definitions under 45 CFR Parts 144 and 146, as well as individuals who have coverage based upon a legally liable third party payer. Creditable coverage would include coverage of an individual under a group health plan, Medicare, Medicaid, a medical care program of the IHS or tribal organization, and other examples as outlined in the rules relating to creditable coverage at 45 CFR 146.113.

- 26. Does an advance beneficiary notice for a medically necessary procedure satisfy the requirement that "[c]laims denied by a health insurance carrier, including a Medicaid contracted managed care organization, for any reason other than the inpatient/outpatient service or services provided were not covered services within the individuals health benefit package are furnished to individuals who have health insurance coverage"?**

The quoted sentence is taken out of context and does not reflect a "requirement." The underlying requirement is that, to be included in the calculation of the hospital-specific limit, the services at issue must be furnished to an individual who does not have "health insurance (or other source of third party coverage)." As indicated in the sentence prior to the quoted sentence. "[t]he costs of services for individuals who have health insurance are not included in calculating the hospital-specific limit, even if insurance claims for that particular service are denied for any reason." And the following sentence states that services are considered to have been provided for an individual with health insurance or third party coverage even though a claim has been "denied due to improper billing, lack of preauthorization, lack of medical necessity, or non-coverage under the third party insurance package." While the quoted sentence may have been inartfully drafted, the overall meaning is clear. The quoted sentence does not indicate that costs related to denials for non-coverage automatically qualify for inclusion in the hospital-specific limit; it simply indicates that certain denied claims cannot be included in the cost limit. When a claim is denied as non-covered, the hospital may then wish to verify that the individual was actually insured, and that the insurance was creditable coverage. Both the statute and the rule clearly indicate that costs of services for individuals who have health insurance (or other source of third party coverage) are not included in calculating the hospital-specific limit, even if insurance claims for that particular service are denied for any reason.

- 27. The preamble states, “To the extent the Medicaid payment does not fully cover the cost of the inpatient or outpatient hospital services provided, the unreimbursed costs of those services would be counted in calculating that limit.” Some hospitals have interpreted this language to mean that any services provided to Medicaid beneficiaries but not reimbursed by Medicaid should be treated as uninsured. Is this interpretation correct?**

The interpretation referenced in the question does not accurately reflect the provisions at section 1923(g)(1) of the statute which expressly refers to uncompensated costs of furnishing hospital services to individuals eligible for Medicaid or individuals who have no health insurance or other third party coverage. If an individual is Medicaid eligible on the day they received medically necessary inpatient or outpatient hospital services, then those services (to the extent that they are allowable under the State’s plan) would be included in calculating the Medicaid portion of the hospital-specific limit.

- 28. How should States count costs not otherwise covered for individuals in an IMD (as Medicaid shortfall, uncompensated care costs, or not included) for those individuals with Medicaid ages 22-64 while in an IMD if the individual is also a dual eligible (Medicare)?**

For the costs of services provided to those patients between the ages of 22 and 64 who are otherwise eligible for Medicaid, the treatment of the service costs in the hospital-specific limit may vary based on State practice. Many States remove these individuals from eligibility rolls for administrative convenience (and must reinstate them if they are discharged from the IMD); if so, the costs should be reported as uncompensated care for the uninsured. States that do not remove the individuals from the Medicaid eligibility rolls should report the costs as uncompensated care for the Medicaid population. Therefore, the costs of services provided in an IMD to an individual who is 22-64 and who is otherwise Medicaid eligible, can be included either as uninsured uncompensated or Medicaid uncompensated in the UCC, depending on the eligibility status (as determined by the state) of the individual while in the IMD.

For dual eligible patients ages 22-64 old in an IMD, the treatment of costs would be determined by the State Medicaid eligibility policies. In States that do not remove the individual from Medicaid eligibility, these dual eligibles are Medicaid eligible and their uncompensated costs should be included as Medicaid uncompensated costs. In States that remove such individuals from Medicaid eligibility rolls while in an IMD, these individuals would be Medicare only during the IMD stay and therefore considered to have third party coverage (Medicare). Uncompensated care costs would therefore not be allowed in the uninsured uncompensated cost portion.

Hospital Data

- 29. Because hospitals may not have detailed cost center-specific charge information for uninsured and Medicaid MCO patients for prior years, would it be acceptable to allocate total uninsured or Medicaid MCO charges to specific ancillary cost centers based on the percent to total of Medicaid charges, or, should uninsured or Medicaid MCO costs be disallowed entirely for these hospitals?**

We expect that State reports and audits will be based on the best available information in conjunction with guidance from their independent auditors. If audited Medicare cost reports are not available for each hospital, the DSH report and audit may need to be based on Medicare cost reports as filed. We note that hospitals must follow the cost reporting and apportionment process as prescribed by the Medicare 2552-96 cost report process. To the extent that these cost reports do not contain the precise information needed for the DSH calculation, it may be necessary for hospitals to modify their accounting techniques. In those circumstances, for the initial audits, it will be necessary to use other source materials such as audited hospital financial

records and other records, and to develop methodologies to determine the necessary information from such records. We expect States, independent auditors and hospitals to work cooperatively to develop such methodologies.

CMS has developed a General DSH Audit and Reporting Protocol which will be available on the CMS Web site that should assist States and auditors in utilizing information from each source identified above and developing methods to determine uncompensated costs of furnishing hospital services to the Medicaid and uninsured populations. The protocol is available on the CMS Web site at: www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2198FRptProtocol.pdf.

30. The regulation requires use of a Medicare hospital cost report to provide data to States and CMS. Some children's hospitals do not care for a large number of Medicare patients and may not file Medicare cost reports or may provide low utilization reports. Is there an alternative reporting tool that children's hospitals could use and still be in compliance with the regulation provisions?

We anticipate that States and auditors will use the best available and most accurate data. The DSH reports and audit will rely on existing financial and cost reporting tools including the Medicare 2552-96 cost report as well as audited hospital financial statements and accounting records in combination with information provided by the States' Medicaid Management Information Systems (MMIS) and the approved Medicaid State plan governing the Medicaid payments made during the audit period. If a hospital (e.g. a children's hospital) does not file or files only a partial Medicare 2552-96 cost report, the State remains responsible for reporting the information which would have otherwise been available on the Medicare 2552-96 from each hospital for Medicaid and uninsured purposes. In order to fulfill the requirements of this section, States may require such hospitals to provide the same data to the State as if they were filing the Medicare 2552-96.

31. When you say "costs of services" or "costs for dual eligibles" do you mean that this term is interchangeable with charges or do you mean just costs?

A. In the regulation, the term "costs" is not interchangeable with the term "charges."

32. As part of the reporting requirements, is the State required to submit a LIUR calculation for every hospital that received a DSH payment or only for the hospitals which are deemed eligible for disproportionate share based on their LIUR?

Under section 1923(b), hospitals may be deemed as disproportionate share hospitals based on either their MIUR or LIUR. We recognize that some hospitals may be so deemed based on both their MIUR and their LIUR. In order to fulfill the requirements of the final rule, States should submit the appropriate calculation for both the LIUR and the MIUR for these hospitals. We believe this is beneficial to both the State and to hospitals. The report must show that each hospital receiving DSH payments meets applicable DSH eligibility requirements. Should a hospital thought to be qualified under the LIUR but is later found not to be, a determination can readily be made about its potential DSH eligibility under the other formula.

Dual Eligibility

33. Would days, costs, and revenues associated with patients that have both Medicaid and private insurance coverage (such as Blue Cross) also be included in the calculation of the MIUR

percentage and the DSH limit in the same way States include days, costs and revenues associated with individuals dually eligible for Medicaid and Medicare?

Days, cost, and revenues associated with patients that are dually eligible for Medicaid and private insurance should be included in the calculation of the Medicaid inpatient utilization rate (MIUR) for the purposes of determining a hospital eligible to receive DSH payments. Section 1923(g)(1) does not contain an exclusion for individuals eligible for Medicaid and also enrolled in private health insurance. Therefore, days, costs, and revenues associated with patients that are eligible for Medicaid and also have private insurance should be included in the calculation of the hospital-specific DSH limit. As Medicaid should be the payer of last resort, hospitals should also offset both Medicaid and third-party revenue associated with the Medicaid eligible day against the costs for that day to determine any uncompensated amount.

34. The regulation states that costs for dual eligibles should be included in uncompensated care costs. Could you please explain further? Under what circumstances should we include Medicare payments?

Section 1923(g) of the Act defines hospital-specific limits on FFP for Medicaid DSH payments. Under the hospital-specific limits, a hospital's DSH payment must not exceed the costs incurred by that hospital in furnishing services during the year to Medicaid and uninsured patients less payments received for those patients. There is no exclusion in section 1923(g)(1) for costs for, and payment made, on behalf of individuals dually eligible for Medicare and Medicaid. Hospitals that include dually-eligible days to determine DSH qualification must also include the costs attributable to dual eligibles when calculating the uncompensated costs of serving Medicaid eligible individuals. Hospitals must also take into account payment made on behalf of the individual, including all Medicare and Medicaid payments made on behalf of dual eligibles. In calculating the Medicare payment for service, the hospital would have to include the Medicare DSH adjustment and any other Medicare payments (including, but not limited to Medicare IME and GME) with respect to that service. This would include payments for Medicare allowable bad debt attributable to dual eligibles.

35. Is it CMS' intention that dual eligibles would include individuals with Medicare for whom Medicaid pays only Medicare deductibles, coinsurance, or Medicare Part A or B premiums?

For the purposes of the DSH audits and reporting requirements, dual eligibles include all individuals with Medicare who also are eligible for some form of Medicaid benefit. This includes those individuals for whom Medicaid pays only Medicare deductibles, coinsurance, or Medicare Part A or B premiums.

36. Medicare DSH allows hospitals to claim additional Medicaid days beyond the paid days for patients with commercial insurance through their employer and Medicaid. Would these patients be included in Medicaid DSH since they are Medicaid eligible?

The Medicare DSH program and the Medicaid DSH program are separate programs authorized by different sections of the statute and with different purposes and goals. If the patients are Medicaid eligible, then costs and revenues associated with inpatient and/or outpatient services furnished to them must be included in the hospital-specific limit calculation. Revenues required to be offset against a hospital's DSH limit would include any amounts received by the hospital by or on behalf of the Medicaid eligible individuals (for any days those individuals remain Medicaid eligible) during the Medicaid State plan rate year under audit (except payments from State or local programs based on indigency).

ARRA

37. How is the DSH audit and reporting rule affected by section 5002 of the American Recovery and Reinvestment Act of 2009 (ARRA)?

DSH payment adjustments made using the ARRA increased state allotments are subject to DSH audit and reporting requirements. ARRA provided additional potential fiscal relief to States by increasing most States' Federal fiscal year (FFY) 2009 and 2010 Medicaid DSH allotments by 2.5 percent. Specifically, section 5002 of ARRA amended section 1923(f)(3) of the Act to provide a temporary increase in state DSH allotments for these fiscal years. Section 5002 of ARRA did not otherwise modify DSH requirements. States are required to follow the same requirements for payment adjustments made under the increased allotment as they would for any other DSH payment adjustments, including DSH reporting and auditing requirements.